

Thinking on the Front Line

Why some social work teams struggle and others thrive

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Abstract

This is a study of problem solving by social workers and analyses what supported or prevented creative thinking. It is a multiple-case study of three social work teams working with vulnerable adults at risk of abuse and those with borderline traits. The three teams respectively: supported people with disabilities in the community; arranged care for people discharged from hospital; and helped homeless mentally ill people.

The psychoanalytically informed observations provided depth insights into the unconscious preoccupations of the teams through counter-transference. These allowed understanding of the emotional meaning of the work for each team, the anxieties against which the teams were defending, and the unconscious contribution of the service users.

Interviews informed a meta-comparison between the teams. This identified five enabling factors that influenced their ability to function well: the coherence of policies, the degree of professional development among staff, the availability of mental space for creative problem solving, the level of autonomy assumed, and the availability of support structures. The importance of sensitivity to the emotional meaning of the work became evident, and the value of training and learning opportunities.

The study found that the team which used mental space - through case discussions, supervision and shared working - helped a challenging client group, made a business case for resources, and was sensitive to the emotional undercurrents. But it found that the teams which had limited mental space and supervision, due to lack of staff and high demand, were less able to focus on creative problem solving.

The research concludes that all five enabling factors are crucial for social work teams. It makes a number of recommendations to encourage best practice, including training in clinical supervision and management.

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Chapter 1

Introduction to the study

‘Social work is quite largely counteracting disintegrating forces in individuals, families and in localised social groups’.

(Winnicott 1965 p 227)

Introduction

This introductory chapter starts with a definition of social work that clarifies its dual purpose. It considers the political, social, and policy changes that have influenced social work during my career. It explains the research question and explores the content of the thesis chapter by chapter.

A definition of social work

‘However the goals of social work may be expressed at any given time, they are essentially concerned with enabling people to make a better go of it with themselves and others and to achieve or have provided for them more elbow room in their social circumstances.’

(Younghusband 1974 - Foreword)

The two elements described above form the warp and weft of social work. The ‘enabling’ knowledge and understanding of human growth and development with the conscious and unconscious elements of relationships form the warp, while the more practical assessment and provision of services or ‘elbow room’ make the weft. These two aspects: practical problem solving and support on one hand, and challenging or encouraging relationship changes on the other, weave together the fabric of social work. Social work entails both ‘surface’ issues (Cooper 2005) eg living alone, handicapped aged over ninety, and ‘depth’ issues of loneliness, loss, or cursed determination.

The proposal

How do social workers think on the front line?

What supports their thinking and what gets in the way of it?

The purpose of this study was to look at current social work practice, and to see how far social workers were able to be creative in helping their clients to 'make a better go of it' given the surface and depth impediments to the task. The study looked at three teams working with vulnerable adults at risk of abuse and those with borderline traits. Social workers are involved with people on the cusp of psycho-social crises. These are stressful both for the service user and the social worker. The latter are under considerable pressure to 'solve' the problem, knowing that the wider world is watching and ready to criticise any false move. The ability of social workers to think is under constant attack from clients, from authority figures in our blame culture, and from their own internalised issues. Hence the professional training of social workers and the support structures in their workplace aim to facilitate the ability to think. But can they do this in practice; and is more support needed? (see Appendix 1 p204).

Influences on the researcher

The thinking that influenced my research developed at a number of critical times. For example, when the Home Office wanted to increase the number of child care social workers, it set up emergency courses for mature students under the guidance of Clare Winnicott (Kanter 2004), one of which I completed in 1970. As might be expected, there was considerable focus on the social sciences, human growth and development, the psychodynamics of families, skills in communicating with children and the legal framework, as well as the opportunity to develop self-awareness and insight. This encouraged a reflexive view that became part of my professional self.

The focus of my work was to develop shared experiences with children. They could use the unthreatening neutral space – of a car journey or meal - to share the sad or angry feelings inside them. This helped them stay emotionally alive and maintained their capacity to feel (Winnicott C.1964), while efforts were made to rehabilitate them with their families or to construct a separate life with the support of house mothers or foster carers.

The first structural modernisation of social work (Great Britain 1968) brought together the Welfare, Mental Welfare and Children's departments under one roof along with some different views of social work. Social workers varied from practically orientated Welfare Officers, working with older people and those with physical handicaps in the community, to psycho-dynamically orientated Psychiatric Social Workers. Lord Seebohm's vision had been to increase the bargaining power of 'welfare' to equal or supersede that of the housing departments in local authorities (at the time of 'Cathy Come Home' BBC 1966) as well as to provide a single entry door for all needy people to walk through. He had not expected a move to generic social work (Lord Seebohm, personal communication November 1972).

These changes provided a new beginning. An expanded and radicalised young workforce was inspired by visions of social equality and social justice. Social work was embedded in a community development model of innovative outreach schemes for all client groups and a focus on community resources. Social workers in the inner city borough where I worked ran drop-in centres for the mentally ill, support groups for young mothers, neighbourhood warden schemes for the housebound, and diversion schemes for youngsters in trouble etc. They wanted to become more accessible, holding sessions in GP surgeries and clinics as well as a stall at the local market. I enjoyed developing a responsive system to attend to generic community needs by setting up an early intake group (Bourne 1972) in 1973.

However this freedom to innovate did not last. The Maria Colwell Inquiry (Great Britain 1974) put responsibility for preventing child abuse and child deaths firmly on to social workers, with none of the structural anonymity of previous systems (Waddell 1989). A steady stream of Child Death Inquiries throughout the 1970s and 1980s (Reder et al 1993) increased the resources needed to investigate allegations of abuse at the expense of preventive work with families. Society was impatient of anything less than total safety for children, complaining both of incompetence and interference by social workers.

Meanwhile the tensions within the amalgamated profession continued. They were highlighted by the national social workers strike in 1979, which polarised the workforce. These two sides seemed to represent

‘the unresolved dichotomy between a) the explanatory theories which stress external factors in the miseries and distress which clients experience and b) those which stress internal factors, whether individual or familial.’ (Stevenson 1991 Foreword).

This conflict has affected the uptake and use of psycho-dynamic thinking in the profession to this day. It has led to a political misunderstanding on the role of social work. Social workers cannot help people to achieve change in their behaviour or relationships without also having a relationship with them (Scottish Government 2006). Relationships with distressed and difficult people impinge directly on a social worker’s ability to think.

My role in an in-house training and development section in a social services department helped the organisation provide a more containing space to support all the employees in their different roles. An MA in Public and Social Administration enabled insight into the ‘surface issues’ of social work that could help or hinder working practices. My supervisor for the dissertation (Barker 1982) shared her thinking on the value of supervision and its psychoanalytic underpinning structure. This encouraged me to complete an advanced course in consultation to organisations, groups and individuals at the Tavistock Clinic, which gave further understanding of the unconscious - or depth - issues in groups and organisations (eg Crawford 1986). I became job-share training manager (Grimwood & Popplestone 1993), then sole post-holder. During my time in post, the section earned the sobriquet of ‘being the oil in the joints of the department’ (personal communication, Ann Kutek, verbal evidence to Social Services Inspectorate 1993).

But during these decades the leading figures in social work education, management, and central government bodies were unable to launch an effective joint defence of social work practice. This allowed political underestimation of the demands on social workers and a continual erosion of standards in the physical operating environment. Lord Laming’s bleak descriptions (Great Britain 2003) of ill-managed and poorly resourced offices mirror the neglected and abused children whom they were failing to serve. These descriptions contrast starkly with the comparative success of some well-managed social services departments, which had progressed to become supportive ‘learning organisations’ (Rosen et al 2003).

The NHS and Community Care Act 1990 (Great Britain 1990) introduced radical change by treating service users as consumers. All the complexities of the market economy – commissioners, providers, inspectors and auditors - were introduced. The commissioning of training services split the training officer and the service manager. They could no longer be the parental couple in the unconscious of the staff group. This removed another source of support in a difficult environment. It hastened the perception of knowledge as a commodity, rather than a route of personal development towards self-actualisation (Maslov 1943, Knowles 1973).

Vanishing organisations

A recent commentary on modern day organisations (Cooper and Dartington 2004), highlights their fragility in the networked world. This refers to ‘the shift from the human to the mechanical, from judgement to procedure’ in social welfare (p136). I experienced this first in my training department, and then as follows. The Central Council for Education and Training in Social Work (CCETSW), which had been responsible for the development and regulation of social work education since the Seebohm reforms of 1970, was dissolved in 2000. This coincided with devolution in Scotland and Wales. Responsibility for social work and social care education and training was split between the four countries of the United Kingdom. England’s structure was further split between the General Social Care Council (to register social workers and to regulate their education), ‘Topss England’ (a member of the Sector Skills Council set up to provide workforce information and occupational standards across social work and social care) and the Social Care Institute for Excellence (an enhanced National Institute of Social Work, to develop the underpinning knowledge and the research ethos needed by the profession). Given my workforce knowledge and occupational standards work in CCETSW, I joined Topss England.

I experienced the new environment of a post-modern ‘virtual’ organisation. Based at home 200 miles from the office, I shared with eight colleagues the task of defining and responding to the training needs of 1.4M people in the workforce. I led the development of a mental health training framework across social work and social care. We had no informal and little formal contact with each other and no local administrative support. The IT system, on which we were reliant, closed for two months when the server broke down. Supervision was rare and there seemed to be no management solutions to the

demands being placed on the organisation. I understood my feelings of unease when I read

‘The experience of workers remains unacknowledged whilst sweeping claims continue to be made for what agencies can do: more and more with less and less’ (Preston Shoot and Agass 1990 p119).

In parallel, mental health social workers were being seconded from their local authorities to ‘integrated mental health trusts’. Over the next few years, the small workforce of about five thousand Approved Social Workers continued to safeguard the integrity of assessments and community reports under the Mental Health (Amendment) Act 1983 (Great Britain 1983). The only acknowledgement of their work was from the Mental Health Act Commissioner (Clayton 2002). I attended a central planning group at the Department of Health. Nobody there even knew that social workers had a specific role in mental health. The isolation of social workers in Community Mental Health Teams (CMHTs) resonated with my situation.

Fortunately there were other ways to help mental health social workers and support workers in their new inter-professional roles. A small group (my advisory group from Topss England, and supervisor at the Tavistock) set up a space for debate and discussion on ways to develop a social perspective in modern mental health services. This space, which we called the Social Perspectives Network or SPN (www.spn.org.uk), was used creatively by academic colleagues, service users, social workers, voluntary organisations, central government policy makers and others. Securing funding over five years, we established a containing space to support social workers and help them to articulate and reflect on their role in mental health services (Foster 2005), and to implement creative change in an equal partnership with others.

Why look at thinking on the front line?

Policy makers and academics often say that social workers ‘ought’ or ‘should’ be doing or thinking such and such. But they, like me, have usually stepped back from front line work some years before. I was curious about actual practice in the field, rather than speculation and hearsay. Was social work in the first decade of the twenty first century so different from my experience? Did social workers have options when making decisions or were these mainly prescribed? Was there space to think amongst all the doing? What inhibited thinking and what helped? For instance, was supervision – on

which much emphasis had been placed - the life-line that we hoped? Were the organisations still recognisable or had they changed and fragmented in new ways?

I set up case studies of three ordinary social work teams selected from contrasting groups who thought that their staff would be interested in the project. The information sheet which I sent out probably resonated with their experience

‘The social work role may have changed over time but it is still relationship-based. Social workers therefore have to think both cognitively and emotionally about a situation, as well as take account of the unconscious dynamics. Encouragement to use evidence-based practice, critical and reflective thinking or assessment frameworks may not fully take account of what actually happens in the field.

For instance, what reduces our ability to think straight? Certainly we are affected by strong emotions such as fear, anxiety, and sadness. Then there are the preoccupations of living, the working environment, and sheer overload etc. In the main, we recover our ability to think - but how? The researcher would like to look, listen and understand what happens during the working day in three different teams. She will try and understand what its like for social workers and what happens to their thinking as they do their job – when is it swamped and when does it survive?

The researcher is not focussing on any individual’s work but on the dilemma that is part of the job itself. With the integration of services and weakening of local authority links, it is important that the profession can say ‘This is what we do and how we do it’ (see Appendix 2 p216).

The structure of the thesis

The literature review in Chapter 2 starts with an extract from one of the thirty seven interviews – ‘Jill’s tale’ from a social worker in the first team visited. Her description of a concerning piece of work provides a reminder of the primary task of the research participants. It illustrates the part that a containing space can play in thinking. I explore the psychoanalytic theories that underpin the development of thinking and creativity. I follow what happens to an infant’s ability to think if it lacks responsive and containing care. The link with the development of borderline personalities seems convincing. I comment on the side issue of vulnerability amongst the very old and isolated, and note the risk of abuse. I look at the effect that the work has on a social worker’s ability to think, using commentaries from the Victoria Climbié Inquiry (Great Britain 2003). The danger of psychic overload for social workers overwhelmed by their client’s projections are clear, as is the preventive need to ‘turn a blind eye’. I look at the current provision

of supervision and other forms of mental space to counteract this risk. Research projects are noted which are closely related to mine.

Chapter 3 explores the methodology considered and the methods used. 'Marlene's tale' at the start explains how a social worker helped a severely brain damaged man to change his future. It is illustrative of the type of work that I wanted to capture in my data. I settled for mixed research methods. I developed three case studies, using the ethnographic techniques of participant observation and interviewing. These are overlaid by psychoanalytic reflection on the action and researcher counter-transference. I describe the theoretical foundations of these methods. I look at the ethical issues, and the confidentiality and sense of trust that I developed in the teams. I describe how I tackled the data analysis, the computer technology used, the seminar discussions held, and the debates and reflection around the findings discussed in Chapter 7.

Each of the following three chapters relates to one of the case studies eg the District Team in Chapter 4; the Hospital Team in Chapter 5; and the Mental Health Team in Chapter 6. They follow a similar pattern: beginning with a prologue to explain the start of the relationship, followed by a substantial piece of observation, interwoven with a reflective commentary. This aims to let the reader decide what could be seen and its meaning. I analyse the emotional meaning of the work for the team, and look at the working environment and the space available for them to think. I indicate further theoretical points which helped my understanding.

By Chapter 7 and the main analysis of the findings, I realised that it was not just 'thinking' that I have researched but creative thinking and creative problem solving. By building up a series of codes and pulling the findings together in a meta-analysis, I discovered there are a number of visible 'surface' areas that impinge directly on the ability of the social workers to think. I explore this and develop a measure that could be applied in any team and could stimulate worthwhile discussion. In relation to depth issues, I found two interconnected but different main client groups – those who are highly dependent, vulnerable, and at risk of abuse and those with borderline personality traits. Social workers with a sensitive perception of the unconscious and its processes can work usefully with both groups if given the necessary support and encouragement.

But more importantly they have the potential to recognise and possibly intervene in those difficult and tragic cases where the world 'turns a blind eye' (Steiner 1985).

The conclusion comments on the research experience. This highlights the benefit of using a psychoanalytic approach to participant observation in order to encourage a third position from which to understand the emotional meaning of the work for the teams. It recognises the organisational benefit of interviewing all willing participants to introduce effective change.

The research found five areas that impacted on creative problem solving: the coherence of policies, professional development, mental space, autonomy, and support structures. For instance, the establishment of the General Social Care Council and its introduction of a social work register and post qualifying framework has transformed professional development in the field. However, if social workers are required to confront difficult, deviant or dangerous members of society (Scottish Government 2006) to protect vulnerable children and adults, substantially more attention needs to be paid to their psychological well being through the provision of supportive mental space. The reintroduction of clinical supervision, more frequent use of joint working, case discussions and an expansion of post qualifying training opportunities would help social workers manage the work and counteract the psychological need to avoid painful situations. The implications for practice across the profession are then noted.

The operating environment for the study

The fieldwork for this research project coincided with the splitting up of Social Services Departments. Following 'Every Child Matters' (Great Britain 2004), children and families work gradually transferred from Social Services Departments to local Education Departments. Youth Justice followed Mental Health into multi-disciplinary teams. Social workers were now managed and employed by other professionals. Adult services were joined with other community services, usually under a 'Community Services' directorate. A Green Paper on Adult Social Care (Great Britain 2005) had just been issued for discussion, which led to the personalisation agenda. So, what was it like to be a social worker in an ordinary team, helping people who rarely made headlines while social services departments gradually faded from view?

Chapter 2

Literature Review

‘On the seashore of endless worlds,
Children play.’

Tagore cited Winnicott (1971)

Prelude: Jill’s tale

Social workers provided many descriptions of their work during the interviews which were carried out as part of the research. Jill, a social worker in the District Team, mentioned an upsetting experience

I am working with a lady in her thirties. Her position is very sad. And most worrying for her is her relationship. She is a white lady married to a Moslem man and converted to Islam; they had two young children. She's very isolated from her family because of the drama associated with her marriage. She has a brain tumour and epilepsy and she is very poorly. She hasn't eaten for months. She was very difficult to get in touch with in the first place. I came across her husband. I was astonished; I have never known anyone to be so horrid. This man wasn't play acting. He gave her the divorce papers as I sat on the bed. He was divorcing her because she could no longer meet his needs as a woman and wife. I thought ‘She is dying’. I was there when this happened. He said ‘I'm sick of her and I don't want to have to care for her and I want to divorce her so I can marry someone else and I can't wait for her to go’.

I was dumbfounded. I said ‘Do you realise what you're saying? And how this must affect her?’ he said ‘I don't care I'm sick of her’. She reminded me of a little bird. I don't doubt the fact that he is absolutely fed up with her. But he said ‘She has medication, she doesn't have to be sick.’ I said ‘I'm going to have to stop you. I think you don't really understand what is happening and you are ignorant of her needs’. He said ‘What do you mean?’ I said ‘I'm sorry I have to tell you what I feel’. A little smile came on her face. She honestly thought somebody was at last sticking up for her. I thought ‘This poor woman has to put up with this man. How on earth must she feel about these things?’ I needed to find a service to take this man out of her life.

And bless her, she went into hospital the next day. I phoned yesterday and spoke to her and then to him because he cares for the children. He adores his children and they are his world. In his way he cares for her indirectly. He has to tidy the home and she will benefit that way. And he will cook a meal and she could benefit that way too. But his intention is not to provide care for her. She lives with their children and he lived separately. This is one case I found very difficult. This was abuse.

Then I thought 'This hasn't suddenly happened, he must have had traits of this type of behaviour in the past. In the early days she thought she could live with it but now she realises that she is stuck'. It is very sad. When I said goodbye to her on the phone she started to whimper saying that she just wanted somebody to talk to. I said 'I'm sorry, talk to me. Haven't you seen anybody? Hasn't Ahmed been in with the children?' 'Yes they came on Sunday but he's not bringing them back until Thursday'. So there she is all poorly and with no children and no one else. So I said 'I tell you what. I'm going to make a promise to you. If they leave a little window in my day, I will come to see you'. She said 'Okay, thank you.' So that's where we left it. So I will put it down that I'm doing a visit. That's what I'll do.

Introduction

Jill, quoted above, used the research interview as a containing space which helped her to articulate the issue and to decide on the best course of action. This chapter explores the psychoanalytic contribution to the understanding of the development of thinking. It starts with an infant's thought processes and the nascence of creativity, the difficulties that may be encountered, and the effects these may have on the developing psyche.

The chapter explains the damage that can be done in early years resulting in people developing borderline personalities, and the demands made on mature thought processes when working with such people and those vulnerable adults with high physical or mental dependency. It considers the implications these two groups of service users have for social work 'thinking' within modern social care cultures. The Victoria Climbié Inquiry (Great Britain 2003) and three subsequent papers provide examples of 'surface' and depth' issues in the work.

Studies are examined which explore the role and function of supervision for developing social work thinking. Recent relevant research projects are considered. The case for investing time in this particular research project and subject is made.

Mental development

Early days

Recent advances in neurophysiology and psychology (Damasio 2000) have turned the cognitive/emotion debate on its head. Now that feelings can be proved to exist to the satisfaction of positivists by recording and examining brain activity, there is a fascinating opportunity to explore further the hypotheses of psychoanalysts on the

development of the psychic infrastructure needed to hold thoughts. The concepts of 'attachment' developed particularly by Ainsworth (1977) and Bowlby (1979) and 'resilience' (Reivich and Shatte 2002, but initially explored by Antonovsky 1979) currently inform our attempts to care for children, young people and the socially excluded. However an understanding of the impact of early parental relationships on mental development may also help social workers make effective interventions.

The psychoanalyst W.R. Bion (1962, 1967, 1970) studied and analysed the development of thinking. He coined a number of words to represent his concepts which are used below: for example, he refers to the mother as the 'container' of her infant's fears and terror. This is an active state. She receives the feelings, referred to as 'beta elements', and unconcerned by them, she soothes the baby, and returns them detoxified, as 'alpha elements', and dreamable material.

An infant is born totally dependent on his mother or mother substitute. Even before birth, the mother has influenced the development of her baby through her life style, including the use of alcohol and drugs as well as her moods. For example if she is fearful, perhaps in a violent relationship or anxious, this will be sensed by the baby in the womb. At birth the infant is a collection of sensations held together in his skin, who gradually develops understanding of his boundaries, 'me' and 'not me'; and of the arrival of life-sustaining food and love from the mother. In the first days and weeks the infant can brook no delay between catastrophic hunger and this being assuaged.

Bion (1967) holds that the baby cannot tolerate the frustration of 'no-breast' to respond to his hunger. The baby lets the mother feel his persecutory phantasies through projective identification and ejects the 'bad object' of the bad absent breast. But as the weeks go by – and by six weeks most babies will have had over 150 feeds – he begins to grasp that hunger, food and satisfaction are interrelated. Bion suggests that, as the baby develops an ability to tolerate some frustration, a thought is created from the baby's preconception of the breast and the temporary frustration of no-breast. The thought of the breast bridges the gap between the baby's longing for the breast and its absence.

Bion states that 'an understanding mother is able to experience the feeling of dread that this baby was striving to deal with by projective identification, and yet retain a

balanced outlook' (p104). He shows that as a patient 'needed a personality powerful enough to contain his projections... so a mother serves as a repository for the infant's feelings' (p106). Bion describes how the mother expresses her love for the baby when feeding or holding him. The baby takes in this love and internalises it as a good object, or loving relationship, in his psyche, just as he takes and digests milk (1962).

Bion suggests that when distressed the baby projects beta elements (of fear and hate) of his fragmented ego into his mother. She in her reverie creates alpha elements (dreamable and, later, thinkable good feelings) from these for the baby to ingest and imagine. Quiet rocking and crooning provide the calming reassurance babies need. These are the outward signs of this process of containment and reflection. The infant thus tended will eventually internalise this capacity to manage his feelings and thoughts and develop his own apparatus to contain, understand and give meaning to them through symbolisation.

Sometimes a mother feels her baby's panic and terror as her own, which can immobilise her adult caring capacity. If the mother is unable to act as a receptacle for the baby's projections, he may make excessive use of projective identification in an attempt to rid himself of the continuing persecutory phantasies driven by his unmet need for food and love. This might ultimately break the link between the infant and the breast, which may lead to the destruction of the infant's impulse to be curious on which his learning and development depends (p107).

Creativity

Alvarez (1998), acknowledging our debt to Bion, says 'a mind is a vast panorama of thought-about feelings and felt-about thoughts which are constantly in interaction with one another' (p218). She goes on to explore how infants manage to deal with more than one thought at a time, referring to Bruner (1968) - a cognitive psychologist - who considered that the infant's growing capacity to co-ordinate both sucking at the breast and looking around matched his development of two-tracked thinking. In a subsequent paper (Alvarez et al 1999) she disagrees with Bion that thought is primarily stimulated by frustration. She challenges the psychoanalytic image that pleasurable states are somehow passive, and describes the pleasure and learning a baby obtains from examining the face of its caregiver. She remarks that Wolff (1965) found that babies

showed intellectual curiosity when they were well fed, rested and comfortable, but not when tired or hungry (p194) - an observation with which most parents would agree.

Similarly Pecotic, (unpublished, cited by Armstrong 2002 p90), refers to the child finding a relationship that not only contains its anxieties but can 'receive, augment and return back something that might be described simply as joie de vivre...pleasures of discovery of the world and discoveries within oneself.'

Winnicott was particularly interested in this human curiosity and creativity. He used the term 'creativity' to refer to 'a colouring of the whole attitude to external reality' (1971). He goes on to comment

'It is creative apperception more than anything else that makes the individual feel that life is worth living. Contrasted with this is a relationship to external reality which is one of compliance, the world and its details being recognised but only as something to be fitted in with or demanding adaptation' (p76).

Winnicott put forward the concept of 'potential' or 'transitional' space between the infant and the mother - space of creativity and play. He also developed thinking on transitional objects from his work with young evacuees (Kanter 2004). He explores the way babies acquire 'transitional objects', that not-me but yet very close object, eg a piece of muslin, teddy, or blanket. He notes how these can act as a symbol for a mother's actual presence at the boundaries of sleeping and waking, of being together and separating. He thinks the baby invests the object with meaning and content which enables it to stand in for the mother. I remember the way the face of the 13 month old child crumpled into tears when her mother left the room until she saw her 'ba'. She seized it with delight and rubbed her face into it.

He also explores how a facilitating environment can contain and hold the baby in the mother's absence. The infant can manage to be alone and separate if there is the sense that 'the mother is reliably present, even if represented for the moment by a cot, pram or the general atmosphere of the immediate environment' - a situation that he calls 'ego-relatedness' (Winnicott 1965 p30). This can take place at an early stage, with the amount of ego support needed from the mother gradually reducing. Eventually the infant is able to tolerate the actual absence of the mother. Flash-backs can occur in adulthood when there is a particular positive feel about a place or situation, eg Proust's

madeleines (1913) or the shadows of the trees on the walls of the District Team office (see Chapter 4 below).

Klein et al (1952) would say this phenomenon related to the infant's ability to have internalised good objects (relationships) to provide confidence in the present and future. These allow the individual to tolerate an absence of external relationships for a time. Remembering good objects can provide immediate reassurance when feeling vulnerable or embattled as an adult. These ideas contribute to Winnicott's theory of play (1971) when he says

'There is a direct development from transitional phenomena to playing and from playing to shared playing, and from this to cultural experiences. Playing implies trust, and belongs to the potential space between baby and mother-figure, with the baby in a state of near-absolute dependence, and the mother-figure's adaptive function taken for granted by the baby' (p60).

Britton (1989) in his work on the Oedipus situation introduced a further concept on 'thinking' when he focuses on the creation of 'mental space'. He postulates that while the main focus of this stage in the child's development is the relinquishing of an exclusive relationship with one parent and mourning that loss, the child's acceptance of the parents' joint relationship provides another perspective. By accepting their relationship, the child is now part of a triangular relationship. This gives him the potential to be 'a participant in a relationship observed by a third person and being an observer of a relationship between two people.' The triangular space formed by these benign relationships serves as a space outside the self, which is then 'capable of being observed and thought about' (p87).

Being in this third position allows the child not only to observe the relationship between his parents but to appreciate that he too can be observed. This lets us

'Entertain another point of view whilst retaining our own, to reflect on ourselves whilst being ourselves' (p87).

Fonagy (1991) expands this concept to describe the ability to form representations of other people's mental events, such as someone else's wish or belief, without direct experience oneself. He calls this symbolisation 'mentalising' – 'the capacity to conceive of conscious and unconscious mental states in oneself and others' (p641). He thought this mental development, linked with the development of concern and empathy,

probably starts in a child at the end of its first year and becomes fully active at the age of three or four.

Hannah Segal's work (1957) on symbolisation underpins subsequent research when she explores the infant's concrete use of symbols in his earliest mental life. She calls these 'symbolic equations' to distinguish them from the infant's later ability to use symbols properly - thoughts and words to represent current feelings and earlier anxieties. She places this development in parallel with the integration of good objects in the ego, when the little child begins to feel concern for his care givers.

Sudden strain

Garland (1991) shows the devastating effect of severe trauma on an individual's mental apparatus in her case studies on survivors of disasters. In a state of shock the victims lose the ability to contain and manage their feelings, even losing much of the power of words. They are reduced to trying to manage the flood of terrifying images by projection on to those around them, just as a new born infant does. Those helping at emergencies need help to weather such projective identifications. Garland emphasises the value of having someone who can stay alongside the sufferer with no need to be busy and thus provide a reassuring presence.

She has also found that victims lose much of their ability in symbol formation and regress to the use of symbolic equations described by Segal above. This has a direct impact on their ability to recover

'Since the capacity for symbolisation, and for thinking 'about' something (an event which itself is over) is a necessary part of working through - of dealing with, of laying to rest - a psychically painful experience' (p509).

She also deduced that an external disaster that floods the individual's psychic stimulus barrier (Freud 1920) can tap directly into any small pockets of disturbance and unmodified primitive experience that remain within us all.

Finally, and importantly for social work, she reminds the reader that similar assaults on an individual's mental structures are made when they are victims of less dramatic but equally pernicious traumatic events such as physical or sexual abuse, abandonment by a parent, divorce, loss of employment, or the death of a child. Many users of social care

services have been such victims. Social workers probably underestimate the effect of these traumas on the ability of the service users to think and reflect.

To summarise: to function well in the world we need to have a mature mental apparatus that provides us with an internal space for thinking through day to day events and relationships. We need to be able to use words and thoughts to sort through current and past anxieties. Sometimes when we are unable to think clearly because of an overload of impressions or some strong emotion, we can find it helpful to distance ourselves from the material by talking through issues with someone (eg a colleague, companion or supervisor), who acts as an independent container and reinforces our mental space. Often this is enough to help us to feel 'grounded', and connected back to our internalised good objects, and hence able to see a way through a situation.

Borderline personalities

Children, who have had no containing adult to help them develop a thinking and feeling mind, or have suffered persistent abuse and neglect, are likely to grow up into troubled and troubling people who require the support or intervention of social welfare agencies. In psychoanalytic terms their internal and external object relations are severely impaired. Due to indifference, neglect or cruelty, the infant is denied a nurturing relationship with the mind of his care-giver, and subsequent opportunity for developing a mature mental apparatus. Fonagy (1991) points out that various behaviours eg impulsiveness, unstable but intense relationships, identity disturbances, affective instability, inappropriate and intense anger, frantic efforts to avoid abandonment, suicidal threats, a feeling of emptiness and boredom make up the recognised clinical syndrome of 'borderline personality' in the USA (American Psychiatric Association 1987).

Mattinson and Sinclair (1979) explain the similar behaviour of 'problem family' parents through the lack of opportunity to develop a secure attachment in infancy. The devastating nature of such deprivation becomes more apparent with increased understanding of the role of that attachment figure in the development of the infant's mental functioning.

Foster and Roberts (1998) note that many homeless people have spent a childhood in care as a result of parental neglect or abuse. They suggest that

‘Such early experience leads to a state of mind in which emotional containment in the form of relationships and physical containment in the form of a home are avoided’ (p31).

They point out how that we have difficulty in containing our own states of mind when pressured by internal worries or external concerns. We readily project our fears of disintegration and madness on to homeless people.

Adlam and Scanlon (2005) take this further and suggest that homeless people are ‘both psychologically ‘unhoused’ and psycho-socially ‘dismembered’ (p454) - the latter due to their avoidance of social roles and of becoming ‘members’ of civic society. They postulate that these people have suffered severe developmental failure probably through loss, abandonment and failed relationships. These ideas were helpful in understanding the dynamics in the Mental Health Team in Chapter 6 below.

Dependency

The other main category of people who seek help from the social services are those becoming so physically or mentally frail that they are dependent on others for their personal care. Woodhouse and Pengelly (1991) commented that ‘social workers are caught up in society’s own profound ambivalence about the care of its dependent members, whether children or adults.’ (p187) The situation in the following years of individualisation and prosperity has become more extreme. Hoggett (2000) said

‘There is a deep-seated hatred of dependency within our culture which needs to be understood; I fear that otherwise it will leave an irredeemable scar upon the project of creating a better world (p166).’

He reminds us that we are all emotional and vulnerable beings, and considers those occasions when

‘We struggle not to be overwhelmed by feelings and, to the extent that we cannot find the inner resources to contain and give meaning to what we experience, we depend upon others. We depend upon them for reassurance and empathy, to show the strength and confidence in the future that we ourselves cannot at that moment find or just, simply, to be there, reliably and attentively, with us. We call this care, something all of us give and receive (p164).’

Dartington (unpublished 2007) speaks of the tension between the paranoid-schizoid response to an incident - that of the hero fighting back - and the depressive stoical acceptance of learning to live with the good and bad in the world. He suggests that health and social care services need to work with both of these descriptions. Cooper and Lousada (2005) consider that our fear of dependency poses a danger to society

‘It is not dependency that is the problem, but fear and hatred of dependency which destroys the link to the source of support that may be the ground of our well-being (p195).’

They seem to anticipate the dangers which threaten severely dependent people - of being objectified and then depersonalised. The risk of then being abused by their carers is present. Is it possible for an individual to be reconnected to their internalised strengths if they receive that ego support, or care, to which Hoggett refers above? If this is likely, as I contend, can social work practice contribute? These ideas helped in understanding the service user situation in the Hospital Team in Chapter 5 below.

However, social workers are sometimes ambivalent about service users becoming dependent on them. This may relate to an anxiety about their capacity to remain an independent container, and a fear of being drawn in and absorbed by a situation. It may also relate to ambivalence about their own interdependence, and a reluctance to seek or use support at work. The relationship between authority and support is often entangled with echoes of childhood strivings. This has implications for the provision of effective support in the workplace.

How do social work organisations manage pain and preserve creativity?

Facing the unacceptable

In this section I consider how the content of the work, which social workers do, impacts on their ability to think. Three papers written following the Victoria Climbié enquiry are particularly relevant: Rustin (2005) Ferguson (2005) and Cooper (2005). I consider how organisations manage to defend against such pain, and how they might preserve the ability to be creative.

It is already clear from the exploration above that our ability to think clearly is closely bound up with our ability to maintain a contained space within our minds - where we can keep our thoughts, feelings and experiences, and ruminate and connect them to

the past and present. We can think about our clients, their hopes and dreams, their sadness and despair, their anger and deviousness. We can ponder what we could offer to make a difference. It is not always what we imagine. As one carer said 'I don't want her to do anything, I just want her to come and hear what it is like for me to look after Sally' (personal communication Princess Royal Trust for Carers November 2002).

Waddell (1989) considers the relationship between thinking and doing for social workers. She divides this into servicing (doing and acting for someone), and serving ('the capacity to stand by, one's own internal resources at the ready' p25) - recalling Keats (1817) 'When a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason.' She acknowledges the major structural change in society towards the allocation of responsibility which was brought about by the Seebohm reforms (Great Britain 1968) and the Maria Colwell Inquiry (Great Britain 1974). This moved responsibility from the medical and legal hierarchy on to individual social workers, so that they now also 'service' the State. She describes how

'social work brings the individual up against the necessity of tolerating both the pain consequent upon the nature of social realities and the pain of human suffering which together require political as well as individual ways of thinking about them and then acting accordingly' (p33).

She acknowledges the predicament which this twin pressure poses 'making thinking about experience doubly difficult'.

Rustin (2005), citing Steiner's conceptualisation of 'psychic retreats' (Steiner 1993), notes how both social workers in the Victoria Climbié Inquiry and the organisation appeared to want to escape from thinking about Victoria and her aunt, Kouao. Kouao's borderline psychotic thinking invaded the social workers' thinking which became as confused and irrational as Kouao's.

Steiner's (1985) concept of 'turning a blind eye' (the psychic defence of seeing but not seeing such pain and destruction) is relevant. Even while the committee was hearing evidence another child was murdered - not in an inner city but in a rural village where she lived with her father and step mother, next door to her paternal grandparents (Lauren Wright 2001). People had worries about the situation but no-one acted in time. Over four years her nearest adult relatives and neighbours became inured to the

sadistic brutality of her step-mother. They turned a blind eye for their own psychological safety. The local Member of Parliament, Gillian Shephard said the case seemed even worse than Victoria Climbié's 'because it all took place in full view of those people who should have been caring for Lauren'.

Rustin also comments on the limits of Lord Laming's recommendations to extend Child Protection protocols and procedures, describing in detail the unacknowledged facts of the case

'The feelings aroused in doing this difficult work are hard to make space for. They are uncomfortable, and they are liable to cause trouble in the sense of demanding more thought and more work if they are taken seriously' (p17).

Schneider's paper (2005) provides understanding of this situation. Bion used the symbol 'K' for the process of 'getting to know'. He used the symbol '-K' to represent an undermining of that process (misknowing, misrepresenting, misunderstanding a person, a feeling, or a thought). Bion (1962) believed that '-K' was driven by envy but Schneider considered

'Not knowing is a means of safeguarding one's very existence. When an individual's continuity of being is at stake, he is operating in a mode so fraught with panic that he is unable to make use of other people (for example, by means of healthy projective identification) to help him even temporarily to find safety through the use of the mind of another (who is not in a state of panic)' (p 826).

He refers to Freud's (1920) suggestion that the evasion of reality is essential for maintaining one's capacity to use one's mind to process incoming stimuli (p27) hence the 'stimulus barrier' to undertake this function (as does Garland quoted above). He concludes that

'Not perceiving is not simply a failure to perceive; it constitutes a psychic function in its own right: the safeguarding of sanity from breakdown as a consequence of being flooded by more external reality than one is able to psychologically process' (p826).

An understanding and acceptance of this process confirms the need for management and supervision structures to support social workers in this difficult area. However Rustin notes how far the working environment was from any necessary sharing for the staff

'Not talking about and not writing down disturbing observations are examples of the avoidance of thought. In particular it was rare in this case that two minds got together to think about what was going on. The very many people involved seem to have had pitifully few moments of sharing their thoughts' (p17).

As well as considering the immediate impact of such a case on a social worker, Ferguson (2005) points out that social workers enter a relationship already affected by work with other service users. Working with involuntary clients ratchets up a social worker's concern not only for the safety and well being of any children but also their own safety. This stressful fact is often overlooked. For instance a recent national statement on social work (General Social Care Council 2008) makes no reference to aggressive or violent service users.

Ferguson quotes his own research as well as a study of 50 child protection cases (Stanley and Goddard 2002) which tell a shocking tale of physical and psychological violence towards social workers with the consequence that

'The key implication for child protection concerns the ever-present danger that social workers and other child care professionals are not only at risk of real harm and trauma from being assaulted, but that psychologically they become 'captives' to their violent clients' (p787).

Social workers are some of the few public officials without uniforms routinely visiting people at home. This is likely to increase their felt and actual vulnerability.

He points out that social workers will inevitably bring to a new situation their wider experiences of such trauma and the anxieties which these have provoked. If they receive no support from their managers or office colleagues, the situation will quickly become untenable. Referring to the report he points out

'there was a complete lack of attention to process and feelings, no space for reflection, for slowing things down, as the social work office itself was not a safe or nurturing space' (p791).

The report highlights the indifference of senior managers and councillors to the task with which they were entrusted, to the standard of services and the welfare of their staff. They appear to have put more effort into impressing, if not hoodwinking, the joint review team which had recently inspected their services and pronounced them adequate (Great Britain 2003).

Cooper (2005) focuses on the policy implications of Lord Laming's findings. By connecting the debate to Howe's publication (1996) on the 'surface and depth' issues in social work, he explains how the post-modern agenda followed by both the liberal

right and the left has led to an emphasis on 'surface' interactions. We now treat 'service users' (an apposite term) as consumers whose relationship with social workers is restricted to the negotiation and provision of services, rather than the 'depth' issues of personal narrative and connectedness.

As Howe says 'clients are expected to comply and conform; they are not diagnosed, treated or cured' (p88) and

'Practice concentrates on the delivery of material and legal services and the making of performance-orientated decisions and agreements. In this process, welfare services become 'commodified'. The well-being of individuals is more and more reliant on money and markets and not close social relationships. Social ties of support and mutuality are replaced by individualised dealings based on economic transactions' (p93).

Cooper points to the gap in this Inquiry report, as in previous ones, between the recommendations which the Inquiry Chairs make for 'surface' policy and practice improvements on the one hand, and the 'depth' issues of child protection practice on the other. Rather than social work merely being 'a combination of professional skills and personal qualities', Lord Laming's phrase, he concludes these qualities mean

'The capacity to endure emotional and intellectual pain and simultaneously exercise measured thought, analysis, and judgement' (p155).

Cooper argues for emotionally literate policy that takes account of the difficult feelings and emotions with which both social workers and service users have to contend. The recent dissolution of Social Services Departments and the move of Children and Families work to the Department for Children, Schools and Families (DCSF) in 2007 may perhaps free up local policy making in this way. Certainly one London Borough is currently reorganising its children's work in an innovative way on these principles (Gulland 2008).

Mental space for organisations

Inevitably organisations working with people in difficulty have to manage their projections; otherwise they run the risk of replicating the damaged or malfunctioning psyches encountered by staff. The extent to which the organisation manages these processes creatively or defensively impacts on the social workers and the work. There is a considerable body of knowledge and thought that has been given to understanding

the unconscious in organisations since Freud first published 'Group psychology and the analysis of the ego' in 1922.

During the development of general systems theory in the 1950s and 1960s Jacques (1955), a Kleinian analyst, looked at the ability of social systems to defend against individual and group anxiety. In describing the effect of introducing a workers' council into an engineering factory he concludes that

'One of the primary dynamic forces pulling individuals into institutionalised human association is that of defence against paranoid and depressive anxiety; and conversely, that all institutions are unconsciously used by their members as mechanisms of defence against these psychotic anxieties' (p 496).

Stokes (1994) considers the number of different 'organisations in the mind' that often have to co-exist and the difficulties that can create for workers. He expands Jacques' ideas to look at the effect of constant change on organisations and how that has reduced their effectiveness and reliability as 'containers' both for the workers and for society. Many of us now depend on more temporary networks. This has removed the ease of projecting our ambivalences on a management hierarchy as observed by Jacques (above). Stokes suggests that this increases the risk of groups scape-goating convenient individuals

'Personal stress is caused by unconscious organisational conflicts, but because the conflict has been forced down to the individual and interpersonal levels, it becomes impossible to address' (p 127).

Menzies used Jacques' theory in her study of nursing (1970). I found this relevant in understanding the dynamics of all three teams, particularly the Hospital Team (Chapter 5). Subsequently members of the Tavistock Clinic, the Tavistock Institute of Human Relations and the Grubb Institute have developed psychoanalytic understanding of organisational and group dynamics to enrich open systems thinking (Miller and Gwynne 1972, Miller 1993, Obholtzer and Roberts 1994).

However Armstrong (2002) points out that the emphasis on pathological group functioning 'risks obscuring the extent to which, for example, defensive processes or strategies can simultaneously carry within them, as a shadow, a stimulus for growth and development' (p 90). He moves the debate away from defensive practice to consideration of organisational creativity. He concludes that the discussion and examination of practice (as in this thesis) may allow groups

‘to approach change more creatively: to approach it less in terms of the language of loss and more in terms of a language of adaptation and development’ (p 96).

Borrill et al (2000) in their study of ‘Health Care Team Effectiveness’ looked at 113 Community Mental Health Teams and concluded that ‘Teams who perceive their performance as highly reflexive are rated as more innovative by external judges.’ This suggests that teams which make use of mental space are more creative than teams that lack this.

Lawrence (1994) takes Winnicott’s potential space as a metaphor for the third space between a consultant and their client. ‘It is the cultural space in which meanings can be discovered. In the third space the ‘meanings’ of the situation can be explored’ (p94). He explains his preference for the term ‘generativity’ instead of the child-like ‘play’ and goes on to ask ‘What are the areas of generativity? The short answer is thinking and thought. Given that all business is reliant on thinking...the capacity to think is the major asset of the people in any enterprise.’

Mental space for social workers

There has been much academic debate (Ixer 1999) on the value of reflection in social work. D’Cruz et al (2007) conclude that the terms critical reflection, reflexivity and reflectivity (Fook 1999) provide ways of interpreting experience differently to improve future action. They also offer a process for questioning how knowledge and theory about practice are generated. Social workers need critical reflection - and researchers need reflexivity - to challenge the assumptions which they and others eg central government or employers, may have made of the help and intervention needed by service users. However, in this thesis I use the neutral term ‘mental space’ (Brittan 1989) to describe all the opportunities for thinking during the working day, without division into sub-categories.

Fleming (1998) puts it succinctly

‘To properly finance a department of professionals to work with the crises of human lives, one needs to strategically budget for space to allow the professional to think clearly about the complex situations facing them and impacting them. To avoid this is not to understand the true costs involved’ (p158).

Supervision

The General Social Care Council has achieved much since its inauguration by introducing individual registration in 2004 and an underpinning post qualifying framework. This gives professional social workers responsibility for updating their own practice as in the nursing and medical field. However social workers have less control in obtaining adequate support in the office and over training resources. A social services office can be a dangerous place, as noted in Lord Laming's report (Great Britain 2003). Social workers are dependent on senior managers establishing a culture, where supervision and other structures can create a 'learning environment' (Rosen et al 2003) or 'reflective environment' (Ruch 2007).

The Social Care Institute for Excellence identifies eight key learning settings in organisations: 'supervision, team meetings, Post Qualifying or Advanced Award mentoring, practice teaching, in-service training, individual continuous professional development, service user and carer participation, and other meetings such as briefings for councillors' (Rosen et al 2003). Most emphasis has always rested with supervision. They do not mention working in pairs as a learning method which perhaps reflects social work's conservative approach to working practices.

When casework as a method of social work faded during the 1980s, so did the experience and knowledge of 'casework supervision' (Mattinson 1992), with its assumption that responsibility for professional development and managerial support might be vested in the same line manager. Marsh and Triseliotis (1996) researching two decades later found that nearly half their cohort of newly qualified social workers did not receive 'good enough' supervision. By the time I consulted on the mentoring skills needed in the post-qualifying framework (Foster 1998), there was widespread scepticism that a line manager was an appropriate mentor for a social worker preparing for this qualification.

However, everyone still agrees that 'supervision' is an essential managerial and professional support for social workers, although the concept is invested with different elements depending on the commentator. Lord Laming's Recommendation 45 was that 'Directors of Social Services must ensure that the work of staff working directly with children is regularly supervised. This must include the supervisor reading, reviewing,

and signing the case file at regular intervals' (Great Britain 2003). Cooper (2005) wonders if he intended the supervisors 'to address the difficult psychological and emotional transactions that child protection work necessarily involves for staff' (p8) - since without this, supervision lacks the critical containing function.

Likewise Rustin (2005) suggests that 'the kind of training and support made available to staff does not seem to have helped them to mobilise more adult mental capacities to cope with the unavoidable emotional disturbance of this difficult work' (p13). Ferguson, like Rustin, calls for

'Supportive systems that are psycho-dynamically aware. Effective supervision and reflective organisational cultures require considered attention to all the emotional dynamics in the work' (p792).

Twenty years earlier, Barker (1982) commenting on a similar tragedy (Great Britain 1981) said that

'the social worker needs to be supported if she is to face the realities of some of her most distressed and disturbed clients, because defensive denial of some of the emotional and social realities inevitably means that the information available for thinking, judging and acting is impoverished and quite possibly faulty as a result' (p10).

The above writers hold a psycho-dynamic perspective. They trust that first line managers will develop the skills to manage both process and task - as described by Hughes and Pengelly (1997). This study provides grounding in basic psycho-dynamic and psychological concepts such as counter-transference, mirroring and the drama triangle, to help managers provide appropriate help.

Munroe (2002) analyses what an employer can do to encourage good reasoning skills in its staff. She refers to the core knowledge and skills that staff need, the decent working environment which allows them to think, and the skilled supervision to help them to be objective. She quotes the Department of Health 'Supervision should include scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner, and providing coaching, development, and pastoral support. Supervisors should be available to practitioners as an important source of advice and expertise' (Department of Health 1999 p109).

Official guidance emphasises that 'high quality supervision is one of the most important drivers in ensuring positive outcomes for people who use social care services' (Lagos & Hatton 2008). The expectations on the supervision process are considerable. The organisation relies on the supervisor for the 'development, retention and motivation of the workforce'. But there is limited guidance available on the knowledge and skills required to provide a containing space in supervision.

Rushton & Nathan (1996) confirm that the powerful feelings aroused in child protection work can affect a social worker's capacity to make rational decisions. Supervisors recognise they had a role to play in responding to these feelings. But the need to inspect and advance the work was equally important. There were signs that the supervisors were not confident that hearing the anxiety would in itself free up the worker to think more clearly. For example, a supervisor says 'If they tell you what they're feeling, what the hell can I do about it?' (p364). In an environment dismissive of feelings and concerned with delivery and performance demands, there is often insufficient confidence and available experience to hold on to the value of providing reflective space and a third position for the worker. Lawlor (2006) for instance emphasises the importance of the supervisor maintaining the boundary of authority with the supervisee in order to be an effective container. By maintaining separateness, a supervisor avoids becoming a 'sponge' to the supervisee's anxieties and demands and remains a helpful thinking presence (p134).

Unless managers have received help themselves to reach a third position in order to think about the difficult dynamics of their work, they are unlikely to be able to help their staff. Indeed, only those managers who have completed a practice teaching award, done a specific course in supervision, or received good quality supervision, can be assumed to have developed these skills. No certified management training for first line social work managers in the last twenty years has covered the skills needed for social work supervision - a fact often overlooked. There is little space within a team leader's working day to be emotionally available in supervision with their staff. In these circumstances it is simpler to attend to the substantial surface guidance mentioned above than to help the social worker to take up the third position needed to reflect on his/her work.

My own experience over some years of managing staff development in a well regarded learning organisation and in the research presented here is exemplified by Ruch (2007) when she observes

‘It is widely recognised that the original tripartite supervision model that embraced management, education and support is no longer the template for supervision provision. The supervisory model that dominates current practice is one based on surveillance rather than support, with the emphasis on monitoring, management and narrowly conceived performance indicators. No longer does supervision help practitioners to connect thinking and feeling’ (p372).

Recent relevant research

There are a number of models of critical thinking and decision-making discussed in a social work context. Reder and Duncan (1997), building on their earlier work (Reder et al 1993), analyse all ‘Part 8’ Reviews in one year and develop a model of assessment to which they refer as a ‘dialectic mindset’. Practitioners use initial information to form a hypothesis about the problem, adding more information through other sources and interviews. After considering alternative explanations they arrive at a synthesis on which to decide action and interventions, similar to the ‘mental simulations’ described by Klein (2000).

Munro (2002) examines both real-life decision-making and decision theory and their applicability to child protection. She concludes that the former is rapid and provides ‘good enough’ solutions, while decision theory with its multiple tree structure is worth using when the cost of error is great, and when reasoning needs to be open and accountable. However both Munro and Reder & Duncan appear to underestimate the impact on thinking and decision-making of the unconscious processes between users of services, individual workers, the teams and the organisation. For instance, they do not take account of the emotional impact of the projections that social workers have to contain and manage.

Klein (2000) found that errors in decision-making can rarely be neatly assigned to faulty reasoning - rather the errant workers are ‘victims of poor design, poor training and poor procedures’ (p268). He concluded from his studies that people like social workers approach problem solving in two ways: a) intuitively, where experience has been internalised, and b) by making mental simulations – comparing current facts with past experience and testing out the ‘story’ or hypothesis.

Several recent research studies have focussed on partnership working in the new mental health trusts (Peck et al 2002) and also investigations into interdisciplinary working (Borrill et al 2000, Hudson 2002) which are relevant to the research in one of my case studies, the Mental Health Team. But they do not focus on the work of social workers in particular, or the concepts of thinking, reflection or decision making. However I did find three studies in the public domain that looked at social work practice and decision-making or reflective practice. But all three were concerned with children and families.

For example, Holland (2004) studied social workers completing the assessment framework for safeguarding children. She analysed a local authority work team and a specialist team in a family centre, and completed in-depth studies of 20 assessments. She interviewed social workers at length and studied video tapes of their assessment interviews. She used her research findings to write a handbook on assessment. For example she found that the assessment forms distorted the family's narrative - which I also found was the case with care management forms. She emphasised the importance of social worker reflexivity in analysing assessment evidence. She suggested approaches to decision making but did not record in her handbook how social workers actually approached this.

Bostok et al (2004) researched safeguarding incidents in three teams in England and Wales. Using the expression 'near misses', they found that examination of front-line practice disappointingly limited the findings to active failures of front line worker error, rather than the more insidious latent failures of management, structures and policies (Reason 2000). This mirrors the dynamics of child death inquiries. They asked participants about forums for discussion, time for reflection, and a reporting system to share practice (p41). They found that there were rarely systems in place to learn from each other (one example of a planned case discussion group) and no time set aside. Thus any learning came from informal discussions with other team members. A service manager is quoted saying that what was needed was 'not more guidance, procedures, or memos saying "Why aren't you doing things?" but actually some time for reflection, and to chew things over' (p 43).

Ruch (2007) on the other hand took an ethnographic approach to two family support teams to provide evidence of the use made of reflective space. She spent six months in each team observing times when they might have the opportunity to think about their practice, and held two interviews with each of the sixteen participants. In an article she explains that the social workers were divided in their approach to reflection, using either 'technical reflective practice', focussing on 'what' and 'how' questions - or 'holistically reflective practice' where they also used personal and professional knowledge to consider why they or their clients reacted in a specific way. Using Bion's theory of containment Ruch suggests that social workers are best serviced in their place of work if they find emotional containment (through colleagues, managers or consultants), organisational containment (through a competent manager) and epistemological containment (through the culture of the team supporting the integration of knowledge into practice). These concepts have been helpful in the analysis of some of my material.

This thesis covers new ground through its focus on the mental space available for social work with adults. The attention it gives to the impact of policy and resource management on social work practice is also unusual.

Conclusions

This chapter has explored psychoanalytic theories on the development of thinking including the development of creativity. It examined the impact of trauma and neglect on a developing mental system, and reflected on the characteristics of borderline and high dependency service users. Children without a containing adult are more likely to develop borderline traits. To be effective, social workers and users need internal space for thinking through situations, and the opportunity to talk with someone acting as a container.

The effect of the work on organisational functioning and the social worker's ability to think is analysed, and the importance noted of mental space to manage this. It is clear that teams with mental space perform better. The importance of supervision for supporting social workers is also highlighted. But it is concerning how little guidance and training on supervision skills is available, nor time structured for this in the schedules of pressed managers.

Current research into social work practice and decision making was found to focus on social work with children and families, and to exclude consideration of the wider environment in which social workers operate. This research fills a gap in studies into social work practice by investigating social work with adults. It takes in the wider environment in which social work is practised, and considers the impact of policies, resources, and the mental and physical states of service users on the availability of mental space.

Chapter 3

Methodology

Prelude: Marlene's tale

I have one gentleman who has narcolepsy - a sleeping disorder. He had been knocked down by a car which impacted on his brain. He had a conventional service but that did not work as he woke up at night and had problems with his aggression. He had difficulties with his mental health. He was frustrated and had problems of loss. He had been accommodated as a child and there was a lot of dysfunction in the family. He had been doing very well up to the accident. Since then he had been in and out of trouble.

He needed direct payments. I took that up as soon as I arrived. I said that we would see if he could manage them. So we gave him the money but it didn't work out. He spent the money on gambling and other things. He took out loans to do up his flat. He would sleep and then work on his flat through the night. The Housing Department were desperate to find a solution. They tried to evict him from his flat as the neighbours were complaining. They said that he had stripped off the boards to the core. He had bought a big Jacuzzi and put this into his apartment. They couldn't get anything out of him.

The police were on his back as they thought he was on drugs. However he wouldn't explain and didn't want to interact much with them as he had been in custody and was black. He was a big man - six foot five and used to do a lot of athletics. He was really rather intimidating and scary. He got into a lot of rows. The police were trying to charge him and get him into prison. When they found him slumped on the floor of the supermarket they thought that he was on drugs and they tried to arrest him and he lashed out at them. They charged him with GBH (grievous bodily harm). Then Housing wanted to kick him out because he was doing unauthorised repairs. They couldn't work out if he was just being stubborn or what was happening.

So I picked up all of the social work problems. I wrote to the courts and to the police to put it all on hold. I got him back into the specialist clinic for assessment. His consultant was still trying to find drugs that would work for him. Because it is a unique disorder they did not know how to deal with it. He used to walk on the road and, before you knew what was happening, he was asleep on the road. His brain would switch on and off and he would fall asleep like a little teddy bear. So there were a lot of issues flying around.

I managed to help turn him round, despite his aggression. Then I managed to get him back into the specialist clinic for counselling. We found a consultant who was prepared to talk through his issues - after all he was a highflier who now had nothing. So he now has ongoing counselling. I talked to Housing and attended a

couple of conferences with them. I said 'If you make him homeless this is a problem that you will have to pick up eventually. Yes he has done a lot of unauthorised repairs, but how can we turn this round?' I said 'Let's put an injunction on him so that he doesn't do these types of repairs.'

Eventually we got him a personal assistant. He would say to her –'Run my bath!'; 'Go and get my meal and put it on the table!' I had to explain to him that the care worker did not come to do all this for him, but to be there to do it with him. There was a lot of swearing and door slamming. It was a real struggle but we managed. We moved his account to a holding account managed by a charity. They make the payments directly to the care worker and do the returns. He only has to be there and work with the care worker. He agreed to have visits every single day.

It's been nine months now, so I think this was a good outcome. The medication is working and he is not falling asleep. He knows where to go. The consultant knows his background and his need for medication. The police are off his back and Housing hasn't kicked him out.

Introduction

Marlene's work with brain damaged service users is one of a dozen examples in the interviews of current social work where adults have borderline personalities. It is included as a reminder of the type of work and sort of practice which the research was designed to investigate.

This chapter defines the research question and notes how the question has developed. It considers the extent to which qualitatively based psychoanalytic research complements an interpretivist and constructivist research paradigm. It debates the most appropriate research design and concludes that this needs to be a flexible design and not fixed. It demonstrates why a multiple-case study provides a firm structure for the research. It presents the researcher's contact with the three cases in a clear framework. It defines the need for a mixed methodology of psychoanalytic and ethnographic techniques in gathering multiple sources of data. It addresses the theoretical background of psychoanalytically informed observation, reflection on the counter-transference, and interviewing. It explores the advantages and disadvantages of each of the methods.

It considers methods of analysing the data. These included computer-aided analysis, seminar and conference discussion. The thematic analysis was formed from reflexive and reflective consideration of the material. They are based on both inductive and

deductive methods which allowed the researcher to build up detailed findings from the data. Finally the chapter considers the impact of researcher support on the process and outcomes.

The research question

My submitted title and research question (Appendix 1) was 'How do social workers think on the front line? What supports their thinking and what gets in the way of it?' There was a further question in the proposal: 'What do the workers see as their task?'

When contemplating possible outcomes, I observed that

'My hypothesis is that the ability of social workers to think on the job (and therefore take appropriate action) will be linked to their mental space. However, the space will often be occupied by anxiety and other emotions. These emotions can be contained by symbolisation (words), which stops them invading the mental space and instead allows productive thought. The effectiveness of the thinking of social workers may therefore depend on their opportunities to symbolise the emotional content' (Appendix 1).

It was likely that the same hypothesis would be true for the team: if the team members were able to debate and discuss issues of concern, then they would be less likely to be driven by the unconscious dynamics to act out problems in the group.

The research question had been defined after a study of literature on decision-making (see Chapter 2). Both studies (Munroe 2002 and Reder & Duncan 1999) produce comprehensive algorithms to aid social workers and their managers to reach good decisions. I became interested in an earlier stage about the social workers' ability to find the mental space to realise that they needed to make a decision. A qualitative study examining daily life in the team that identified the availability of mental space and blocks to thinking would complement the above studies. It would analyse the learning environment available to staff, and observe how they managed the social work task. I hypothesised these factors would influence the thinking ability of social workers on the front line.

The backdrop to social work is changing. The start of this new century has seen the first registration of social workers, with a requirement for professional development against a post qualifying framework and initial qualification at degree level. On the

other hand, the managerial demands of care management and a risk adverse child protection system have required more audits, inspections and inquiries – against a tight financial background for community social care services, which has not eased despite the increased spending on health services. This appears to place contrary expectations on the professional autonomy of social workers. I have considered how these conflicting strands impact on practice.

I wanted to explore the structure and culture of the working environments of social workers in order to find out how they saw their role and tasks. This would help understanding and explanation of the unconscious dynamics, as well as the cognitive and emotional elements of thinking on the front line. Dartington (1994) captures the emotional content of ‘thinking’ when she refers to ‘the capacity to be informed by one’s imagination and intuition’ (p101).

The research paradigm

The research paradigm has been defined as ‘the overall conception and way of working shared by workers within a particular discipline or research area’ (Robson 2002). This research project into social work practice uses psychoanalytic and management theories to interpret the data. Thus it belongs to a small cohort of research practice. But it is positioned in the larger field of interpretivist (Cryer 2000), constructivist, and qualitative research.

The research design

Fixed quantitative research designs are considered to be ‘scientific,’ and their findings are likely to have more weight in the professional community than small scale qualitative investigations. Despite the prestige of the methodology, a quantitative approach cannot provide the rich texture needed to increase the understanding of a procedure such as thinking which is emotional as well as cognitive.

The findings from multiple designed research produce convincing evidence when they incorporate both fixed quantitative methods and flexible qualitative information, such as the investigation into the social origins of depression by Brown and Harris (1978). They address the scientific questions of causality while also providing personal data to

respond to the human questions. More recently MacDonald and Sheldon (1997) conducted research amongst service users with 'severe and enduring' mental illness living in the community to find out what they thought of the social work service. By establishing the randomised selection of interviews, the findings have the rigour to be used as evidence on which to base future practice.

However, my research question was more exploratory and explanatory than either of these. Along with my interest to find out what was happening in the social work field, I became interested in a flexible and qualitative research design such as ethnography. But I was aware that social work teams varied greatly in their ethos and environment, and that the departure or arrival of one or two key staff could impact significantly on group functioning. There was a risk that the findings would have been limited to a compromising degree if research had been necessarily confined to one team. Therefore I rejected pure ethnography with its longer timescales and decided to use a case study approach to structure my research.

Case studies are a familiar tool to explore policy development, where the impact of the different pressures of politics, finance and public well-being can be traced and analysed (Hall et al 1975). However their role in theory development was initially questioned as the approach was not considered to be sufficiently scientific and did not lend itself to generalisation (p14). It was suggested that this could be overcome if case studies of the 'normal' were selected, and if there were a number of cases dealing with similar phenomena so that variables could be observed and compared (Waldo 1962 cited Hall 1975). Thirty years later Jensen and Rodgers (2002) again tackled the accusation that case studies are not able to be generalised. Their answer to critics such as Adams and White (1994) was to suggest the use of meta-analysis – presenting an accumulation of the results of single case studies over time, thus aggregating all the findings in a systematic way.

Yin (2003) defines the purpose of a case study to 'investigate a contemporary phenomenon within its real life context especially when the boundaries between phenomenon and context are not clearly evident' (p 13). I wanted to look at 'thinking' (the contemporary phenomenon) 'in social work teams' (within its real life context) and explore how this was supported or inhibited it (i.e. the boundary between thinking and the social work teams is not clearly evident). Hence the case study design seemed

appropriate. He also considers (Yin 2004) case studies particularly appropriate to examine explanatory questions such as this.

The case study design

I chose to look at 'how social workers think on the front line' by setting up a multiple-case study of three social work teams. They were all of a similar size in similar inner city districts, and all worked with adults. I decided that I would attempt a 'snapshot' approach (Jensen & Rodgers 2002) – as opposed to a longitudinal study (such as the three year case study 'Modernising Partnerships' by Peck et al 2002) or one focused on pre and then post implementation of a procedure or policy. I wanted to find some answers to my research question, and thought that if the findings were compared across three teams as opposed to one or two, then there was more likelihood of generalisations emerging about the underlying commonality of the teams which would provide insights (Jensen and Rogers p238).

The research question was theoretically driven by a psychoanalytic approach to the development of thought and thinking. The research attempted to scrutinise the ability of both individuals and the groups to 'symbolise' during the stress of a working day, using words to express feelings.

The methods I chose to obtain the data to answer my research question needed to be flexible, and the approach to be exploratory, particularly in the first case. Robson (2002) suggests that generalisations are enhanced if the first case study is used to provide evidence which supports a theoretical view about what is going on, and the researcher ensures that the subsequent cases are similarly rich in material. I therefore treated the first case study as a pilot and interviewed all the staff to maximise my understanding of the case. This allowed me to select an appropriate third case for the study, in this instance a multi-disciplinary mental health team working with adults rather than the initially planned children and families team.

Multiple methods of data collection

It was important to be able to trace key constructs and processes uncovered during the research with the use of more than one research method. Triangulation of material

adds to the rigour of the case study structure. I selected a mixture of: interviews, reflection on the counter-transference, and two qualitatively different ways of observing the teams. The first observation method was psychoanalytically informed. I took a distant stance which allowed transference and counter-transference experiences to develop in the inter-subjective space (six sessions in each team). In this aspect of the research and in the later analysis, I used 'particular capacities of mind to observe record and make sense of unconscious processes in the chosen field of enquiry. The study of unconscious processes using clinically based methods marked this part of the research out as psychoanalytic' (Cooper 2007 unpublished).

I was aware of the challenging task of simultaneous data collection and analysis in a case study (Yin 2004). Hence I took a short break in field work to consolidate the data gathered on each team thus far, using it to prepare for the interviews ahead. When I returned in Part 2, I took a participant observer role while negotiating and holding interviews. This involved a more relaxed stance in the ethnographic tradition.

By interviewing social workers I was also creating embedded case studies within the multiple-case study itself. Each interviewed social worker provided personal information that helped to form a view on 'how they thought on the front line and what supported or impeded them'. These embedded sub-cases then contributed to the overall understanding of each of the teams that made up the multiple-case study.

The summary of the multiple-case study in Figure 3.1 below notes the approaches which I made, the social work and multi-disciplinary staff in the teams, the number of observational visits, interviews and participant observation visits made to each and environmental aspects that impinged on the researcher's 'placement' experience.

I considered collecting office data as another source of information. However the senior manager of the two teams, which I studied first, only agreed to the research because it specifically did not involve the staff in any data completion. I assessed whether the study of case files would help to answer questions on some of the longer standing service users in the first team. I established that the 'care management' form was not conducive to exploration of the narrative of the service user (as Holland 2004 noted too). Hence I did not pursue this.

Fig 3.1 the multiple-case study structure

Variables	Case 1 D Team	Case 2 H Team	Case 3 M Team
Negotiation process	Emailed proposal to director, principal officer invited me to management meeting Feb 05. There, service manager D team and operations manager H team invited me to Their team meetings March 05. Teams unanimous in agreeing to research. Agreed to start with D team April 05 and H team September 05		Attended regional meeting of lead social work managers. One passed email proposal to manager. Met team in May 05, agreed to project, excluding supervision. started March 06
Part 1 Psychoanalytically informed observation visits	6	6	6
Part 2 Ethnographically informed Participant observation visits	10	8	8
Interviews of embedded cases (staff)	20	6	11
No. of staff	21 (3 managers, 14 soc workers 1 specialist worker 3 admin)	22 (4 managers, 12 social workers, 2 specialist workers, 4 admin)	18 (2 job-share managers, 1f/t psych 1p/tSHO 1p/t cons psych; 2 f/t 4 p/t CPN; 3 f/t swkers; 1 f/t OT; 3 admin)
Factors to promote engagement	Interest of team members, link person, seat in open plan office, use of kitchen, familiarity with setting, interview everyone.	Interest of team members, initial link person, keenness of managers, kindness of temporary administrator	Interest of team members, link person, seat in open plan office, use of kitchen, my increased research experience
Factors to inhibit engagement	Time taken to establish a rhythm to the research.	Break in visits COREC approval. No link person as the managers left, no seat in small offices, no use of kitchen. Ward focussed.	Group hostility to being observed in Part 1.

Method One: Observation

Psychoanalytically informed observation

Likierman (1997) promotes psychoanalytically informed observation as adding value to the structured findings of social science researchers. In my work I had used organisational consultancy techniques which were psychoanalytically informed (see Chapter 1). I believed that this approach with its recognition of unconscious factors in a group could inform a comparatively short period of participant observation. My skills

were refreshed by the completion of an infant observation and an organisational observation as part of my doctoral studies.

Testing out the method

Before finalising my research proposal, I was keen to experience the potential benefits and pitfalls of my plan to observe social workers on duty. A fellow student provided a contact who arranged for me to spend a Monday morning observing the two Approved Social Workers on duty.

The two duty officers, who were welcoming and friendly, sat in a separate room. They were not part of the team based in the building but had just come in to be on duty.

Unusually there were no referrals from the week-end's emergency duty team to deal with. They pointed to the blank whiteboard on the wall, which provided no neutral material between us for them to react to and for me to observe. So, after some small talk, they described the tasks and functions which they expected to undertake. They then settled down to catch up with their own case recording. My first dilemma was whether to ask them to tell me about the work they were writing up, and whether I could read the screens over their shoulders? I decided not to ask but sat uneasily a few feet from them in this small room. I felt it was going to be an uncomfortable two hours for us all.

Numerous colleagues came to see them and 'observe' me. I was quite startled at the sexualised behaviour of two women staff members towards the older duty officer. One put her arms over his shoulders, stroked his cheek and told me he was the best man in the team. I shrank back with embarrassment. They seemed to want to give me, the voyeur, something 'worth watching'.

The duty officers then were informed about a patient in hospital whose legal status needed ratifying. Three other staff members came in to advise on the best way forward. Lawyers were telephoned, and the next of kin invoked. The rather manic discussion seemed to be another show put on for me to watch. I felt increasingly anxious as the needs of the patient kept slipping from view.

After the morning was over, I thought my presence had too great an impact on the group's behaviour to be a sustainable model for any of us. The persecutory experience of having a passive observer sitting close behind the two duty officers in a small room mobilised such acute anxiety in the group that there was no chance of seeing work 'as it is'. I clearly needed to modify my plans.

What had been going on that I could learn from? First, the duty officers had been 'volunteered' for a pilot observation which had probably not involved the team in which duty took place. Second, I had not discussed the fears and difficulties of being

observed with either the duty officers or the host team. Third, it took place in a confined setting with a limited amount to focus on. This elicited unconscious parallels - first to a Soho sex show, and second to a television drama. Finally I realised that all but one of the seven staff members, who had involved themselves in the observation, were black. This emphasised my visible difference from the group.

Most people feel uneasy at being observed. We often associate another's look with criticism, envy, intrusiveness or hostility. In describing his development of Britton's (1989) work on triangular space, Steiner (2006) concludes that unsatisfactory experiences with the primary object (the mother) lead to guilt, while those in relation to the observing object (the father) lead to shame. He says

'The critical role of the gaze becomes apparent when we recognise that humiliation is an important part of the threat coming from superego figures. This humiliating aspect of the superego is well known but its ubiquity and importance is sometimes underestimated' (p942).

Steiner goes on to quote Segal (2002 unpublished) when she describes 'a patient whose healthy curiosity became transformed into an omnipotent and omniscient voyeurism.' Margaret Rustin (1989) discusses the observer's fears of sharing material in a seminar group

'Our eyes can be felt to function with benevolence, interest and truthfulness, but which may also be felt to be used as weapons to attack, to project unpleasant feelings, to intrude beyond the boundary of what is being offered, or to pervert truthful looking by some kind of distortion' (p10).

If the extent of the conscious and unconscious impact of observation on the observer and the observed is considered, the need for protective manoeuvring by both parties becomes clear. This issue is not confined to psychoanalytically informed observation as Shaffir and Stebbins (1991 below) point out.

The contribution of infant observation to the observer role

An attempt to formalise the observer/observed relationship first developed in infant observation at the Tavistock Clinic when used as a teaching tool for child psychotherapists in the 1940s. This is underpinned by Melanie Klein's theories developed from her studies of young children at play (Hinshelwood 1994), Wilfred

Bion's (1962) theories around containment, and Donald Winnicott's (1958) insights from his work with mothers and their babies.

Esther Bick (1964) refers in her paper on infant observation to 'the central problem of the role of the observer in the whole situation' (p558). She analyses this problem in two parts: the need to conceptualise the observer role, then their conscious and unconscious attitudes. She describes the observer to be

'sufficiently inside the family to experience the emotional impact, but not committed to act out any roles thrust upon him such as giving advice while having enough latitude to be occasionally helpful, in fact a 'privileged and therefore grateful participant observer' (p558).

But she explains the need for the observer to manage any projections from the family

'he is confronted with a situation of intense emotional impact. In order to be able to observe at all, he must attain detachment from what is going on, while finding a position from which to make his observations. He must not allow his behaviour to be dominated by these feelings which, on closer scrutiny, will often be found to have been intensified by projections from members of the family'. (p599).

Margaret Rustin (1989) considered infant observation as a teaching tool. She explored how the impact of observing primitive anxieties in the baby and its care givers provokes different reactions and behaviours in the observers. She saw them as having a 'responsibility only to maintain a reliable, non-intrusive, friendly and attentive presence' (p9). They are encouraged 'to interpret the role of observer as a receptive listening one, not blankly passive, rather following the leads of mother, baby and others' (p10). She considered that the observers will want to find and maintain a relationship which is something in-between the personal and the professional. But she noted that 'The experience of working out one's own personal solution and of living with or trying to shift the imperfections of one's solution can be quite a painful challenge' (p11). While both Bick and Margaret Rustin recognise the intense anxieties that can beset the observer, they give permission to make small adjustments which take heed of differences in babies, mothers and observers.

My single case study had provided limited insight into the potential variations of the role, even with the shared knowledge from the seminar group. Briggs (1997) used his observation of five infants and their families in a comparative case study to examine and develop thinking around maternal containment. But he did not record the differences in feeling and actions at the boundary between himself and the different

families. In the extracts quoted however, he makes it clear that the care givers, the older children, and later the child itself often assigned to him an active or intervening role.

The contribution of organisational observation

In the last two decades 'Organisational Observation' has been developed as a psychoanalytic teaching tool, using some of the framework from infant observations. As in infant observations, the purpose is to develop understanding of the subject, rather than record scientific truths.

Obholzer (2000) explains that the purpose is to 'develop a semi-detached 'visiting anthropologist' in-yet-on-the-boundary state of mind'. Hinshelwood and Skogstad (2000) define the task

'The observer endeavours to keep an eye on three things: the objective events happening; the emotional atmosphere; and her own inner experiences, the whole are of what in the psychoanalytic setting would be called 'counter-transference' (p22).

Likierman (1997) helps students to recognise that all observers

'need to cope with the initial discomfort of stepping into a new setting without the protection of a socially understood role such as that of friend, guest, relative or colleague' (p150).

She notes that 'an appropriate observation stance is not a static position, but a dynamic one that needs to evolve in response to constantly-changing situations.' She sees any actions by the observer in terms of its significance rather than as right or wrong. This helped me question my reactions to a social worker's action 'Why am I reacting like this?' rather than stopping at 'What do they think they are doing?'

Finally Likierman concludes that

'observers cannot assume that they will be able to impose a rigid behaviour-pattern in a live setting and learn from this... authentic adaptation requires not only a constant attunement to events, but also a capacity to retain a core sense of self and role in relation to a changing context' (p156).

This provides a sound structure against which to measure my varying experiences during the three observations analysed in the following chapters.

Its advantages and disadvantages as a research method

Psychoanalytically informed observation can provide unique evidence of a group's behaviour in different circumstances and illuminate its workings. Surface issues (such as desk space, computer systems, and how clients are received into the system) can also reflect depth issues, eg the effect that working with particular client groups can have on a team's functioning. By paying attention to the counter-transference issues (see below) the researcher can gain insights into the unconscious of the team, providing further data on the research question.

There seems to be an unspoken tension in psychoanalytically informed observation whether or not it is 'professional' for the observer-researcher to interact with those s/he is observing. This tension may be between the 'female' view of infant observation, sensitive to the nuances needed to develop the relationship which mirrors a mother's adaptation to her baby, and the 'male' awareness of the need to maintain research standards acceptable to the wider academic community.

Skogstad (2002) outlines ways of increasing the trustworthiness of observational findings. He suggests discussion of the findings in a group, as traditionally done with infant observations, when the 'research instrument can be widened from a single mind to a group of minds' (p83). Cooper (2007 unpublished) also holds that

"the psychoanalytically trained 'thinking mind' will need the help of other equally sensitised minds to unlock and realise the potential of the material. Thus, the clinical research supervisor or peer supervision group become an extension of the psychoanalytic 'research mind'.

I was able to make use of regular seminars and supervision during the project to challenge my interpretations and broaden my vision of the findings.

Skogstad's second recommendation is to separate observation material from the interpretation. I have done this in the following chapters. This frees up the reader to use his/her own judgment on both the observations and the analysis. He also recommends combining the observational data with that drawn from other methods - in this case, interviews. He finally suggests a comparison of the findings to other research on a similar institution. In this case the most vivid recently published description of a social work team is in Lord Laming's Inquiry into Victoria Climbié (Great Britain 2003). Laming covers the surface issues, while the depth issues there are explored in a series

of papers (Cooper 2005, Ferguson 2005, Rustin 2005), hence its examination in the literature review.

Participant observation

White (2001) persuaded me that participant observation using ethnographic techniques could be a relevant method for this multiple-case study when pointing out

‘by attending to how work gets done, rather than to how it should be done, ethnographic data can form the basis for fruitful dialogue between research and practice’ (p114).

I was aware that pressure from a decade or more of inspections and audit had blurred the veracity of factual presentations. I was convinced that ‘seeing for oneself’ was the only way to understand what really went on day to day in a social work team.

An ethnographer would expect to spend from six months to a year immersed in the chosen organisation. Indeed ‘working with people day in and day out for long periods of time gives ethnographic research its validity and vitality’ (Fetterman 1998 p36). However, Shaw and Gould (2001) refer to ‘a range of structured, time-limited approaches to ethnography which can be relevant to the pragmatic character of social work programmes and practice’ (p140). I therefore thought a shorter period of participant observation would be worthwhile. Shaffir and Stebbins (1991) summarise ethnographic fieldwork as ‘immersing oneself in a collective way of life for the purpose of gaining first hand knowledge of a major facet of it’.

But they also recognise the discomfort, the lack of ease at the boundary of the group and the risk of exclusion, showing that the unconscious dynamics can be just as potent when unnamed, eg

‘fieldwork must certainly rank with the more disagreeable activities that humanity has fashioned for itself. It is usually inconvenient, to say the least, sometimes physically uncomfortable, frequently embarrassing, and to a degree, always tense’ (p1).

Method Two: Counter-transference

Can the insight which a researcher has into an individual, group or team’s feelings or behaviour, based on the emotional impact they make on her during the observation, be considered as counter-transference? Or is it some form of researcher subjectivity?

How far are those feelings that of the researcher, stimulated by the team but processed through the researcher's mind? How far are they feelings from members of the team that find a fertile place to grow in the researcher? Is counter-transference a useful concept in research?

I completed a retrospective research of the literature and found that writings on counter-transference in groups and during consultation to groups were relevant to the role of the researcher. For instance Hinshelwood and Skogstad (2000) refer to counter-transference in defining the observer/researcher task above.

Bollas (1987) links counter-transference to 'the unthought known'. As he says

'Counter-transference readiness creates an internal space which allows for a more complete and articulate expression of the patient's transference speech than if I were to close down this internal space and replace it with some ideal notion of absolute mental neutrality or scientific detachment' (p202).

He takes up and develops Winnicott's concept of 'internal potential space' (Winnicott 1971). But he points out that the unconscious dialogue makes it hard to be certain whether our feelings reflect projections from the patient or our personal responses to the patient's world

'This inevitable, ever-present, and necessary uncertainty about why we feel as we do gives to our private ongoing consideration of the counter-transference a certain humility and responsibility' (p203).

I was conscious of this responsibility in my research, and noted that it increased the researcher's commitment to the team. Bollas describes the use of his own subjectivity in his work with patients to illustrate how they should connect with and think about inner feelings. He is always sensitive, offering examples of his counter-transference for mutual scrutiny, and carefully adding more material for the patient to understand.

This more inclusive relationship to an analyst's feelings is taken up by Ogden (1999) with his discussions on the role of reverie in analysis. He argues that Bion (1967) in his concept of maternal reverie provides the theoretical base for an analyst to offer similar containment to his patient. Ogden takes Winnicott's formulation of mental space between analyst and patient, which he develops as the 'analytic third'. He describes this as an asymmetrical unconscious relationship between the analyst and patient (p109). He provides a commentary of his thoughts and associations (the 'reverie' of

the title) which validates the analyst's humanity, feelings and intellect, and shows the genesis of his interpretations.

Bollas and Ogden provided me with the theoretical framework to examine my stray thoughts and occasional role enactment (Ogden 1982) during observations and interviews.

Counter-transference in groups

The application of psychoanalytic theory to groups and organisations started with Freud (1922) himself and the publication of *Group Psychology and the Analysis of the Ego*. De Board (1978) describes how Ferenczi's development of the concepts of projection and introjection in social groups in 1916 provided further foundation for group theories. The psychologist Kurt Lewin (1948) had considerable influence on the development of theory for group dynamics, with his understanding of motivation in groups. In 1946 the first joint training courses or 'T groups' were set up jointly by Lewin and the Tavistock Institute of Human Relations.

In the United Kingdom Bion set up groups for mentally ill soldiers in the 1940s and 1950s. He used this experience to develop far-reaching theories of group behaviour (Bion 1961), noting that groups started with particular basic assumptions in their relationships eg of dependency, pairing or fight/flight. He acknowledges (p148) that interpretations of group behaviour might well owe more to the subjective reactions of the analyst than to the evidence observed in the group.

However he states that projective identification is prevalent in groups. Therefore 'many important interpretations in group treatment have to be made on the strength of the analyst's own emotional reactions' (p149). Bion suggests that the analyst can realise when he is in the grip of projective identification because the counter-transference (which comes over as meaning the emotional fabric of the situation) has a particularly manipulative quality. This definition may be particularly helpful for the observer to hold in mind.

Armstrong (2005) explores what happens to a consultant in an organisation, in particular how the projections of the group of users on to the staff are then projected on

to him. His reflection about the work and attempt to define the analytic object at the heart of the organisation led him to name this as 'emotional experience' (p53). Given his experience of thinking, reflecting and interpreting at several different levels, he commented

'It is not so much how we understand the conscious and unconscious processes underlying emotional life in the organisations as their meaning: what they have to say about the organisation as a system in context. It is in this sense that emotion in organisations – including all the strategies of defence, denial, projection and withdrawal – yield intelligence. And it is because they yield intelligence in this way that they may be worth our and our client's close attention' (p93).

I applied this form of analysis to each of the teams when examining observation records (see the following chapters), and found it facilitated valuable insights.

Halton (1994) suggests 'the psychoanalytically orientated consultant takes up a listening position on the boundary between conscious and unconscious meanings, and works simultaneously with problems at both levels' (p11). I have symbolised this by annotating the record of my field observations in the following chapters. He points out that splitting and projection exploit the natural boundaries between insiders and outsiders. He notes that 'recipients of a projection react to it as if it is their own. Projective identification often leads to the recipient acting out the counter-transference derived from the projected feelings'. This implies that he considered the projections come first, followed by the counter-transference.

Moylan (1994) counsels consultants to develop their ability to listen, since people so often only hear what they expect to hear or are comfortable with and screen out the rest. She suggests we can hear and learn if we attend to the atmosphere and our own feelings - not just to what is being said but the emotional content. She echoes Heimann (1960) in saying that any one-off experience needs to be borne out by subsequent information. I found that discussion of material in the seminar group counteracted tendencies to pick up the familiar and comfortable and to ignore the unexpected or contentious signals.

Fromm (1941), in his examination of our need to belong to groups, explored the way whole societies use unconscious dynamics of projection and splitting eg to unite against a common foe, such as the development of Nazism. Gordon (1999) adds that

Fromm believed psychoanalysis, rather than being inward looking, should address the psychological phenomena which make up the pathology of contemporary society (p 149). When visiting Dublin during the Troubles, I was struck by the good-natured friendliness of the day to day interactions of the inhabitants. It was easy to surmise that negative aspects of society had been projected on to the terrorists, who were active beyond the city.

However Gordon (1999 p143) also cites Samuels (1993) on the limitations of applying psychoanalytic concepts to wider society

‘If we are interested in envy and greed, then we will find envy and greed in capitalistic organisation....so often this is just more of the maddening rectitude of the analyst who has forgotten that we influence what we analyse’ (p9 -10).

Preston-Shoot and Agass (1990) explore more directly the role that social work and social services play in contemporary society. They note that the role of social workers can be made difficult by the projections and denials from government, the media, our legal system and society at large. The social workers struggle with feelings of worthlessness from this counter-transference.

While the term counter-transference is rarely singled out for specific mention in organisational consultancy literature (except in the above examples), there is an expectation that the consultant will use all her senses to engage with the emotional undercurrent of the organisation, and to try and understand its state of mind. It is comparatively rare to include the researcher’s emotions in the summation of research evidence, whether they are subjective or projected from group members as counter-transference. However I found that understanding these feelings provided a different depth insight into the teams. They also highlighted the need for emotional integrity, as mentioned by Bollas above, on which much of the trust in the project rested.

Its advantages and disadvantages as a research method

It is unclear how far counter-transference is a useful word to describe an observer’s experience of organisational culture and aspects of its emotional meaning. Some feelings will be subjective and others projected. That is what happens between people. But one could argue (as do Bollas 1987, Ogden 1999 and Armstrong 2005) that the observer’s subjective thinking, reflection, reverie and rumination, are in part prompted

by unconscious elements in the individuals, organisations, and groups with whom they work. This is equally true for an observer-researcher, and these feelings provide important data - whether counter-transference or subjective.

Ogden's efforts (1999) explored the reverie and thoughts which he had in analytic sessions with his patients and linked them to the work of the session. This underlines the fact that everything that happens in an observation is pertinent. Valuable unconscious insights may become evident if these musings are considered rather than ignored. Indeed he suggests that a focus on his own emotional state can induce 'a feeling of intense emotional immediacy and a resonance with the patient's unconscious experience in the present moment' (p 77). This was occasionally my experience in the field and underlined the need to be trustworthy.

Kleinman (1991) makes a clear link between a field-worker completing a naturalistic study and Ogden's work

'Fieldworkers do not think of feelings as disturbances that impede objectivity and thus should be overridden. Rather, feelings become resources for understanding the phenomenon under study' (p184).

Method Three: Interviewing

The position of the interview in a research project can vary considerably from being the only source of information for analysis and interpretation (Buckner 2005; Cartwright 2002; Hollway and Jefferson 2000) to the provision of confirmatory or additional information for other methods. I wanted to use the interviews to provide further and different data for triangulation. Fetterman (1998) sees interviewing as

'the ethnographer's most important data gathering technique. Interviews explain and put into a larger context what the ethnographer sees and experiences' (p37).

To focus on this, I asked open-ended questions to explore how social workers thought about difficult situations, what resources they called on, and what brought about successful situations - treating each as an embedded case within the multiple-case study.

I appreciated the impact interview material could have on the research, the researcher and the reader. Fetterman (1998) confirms that

‘quotations allow the reader to judge the quality of the work – how close the researcher is to the thoughts of the participants in the field – and to assess whether the researcher used such data appropriately to support the conclusions’ (p12).

I adopted the view of Hollway and Jefferson (2000) that each interviewee was a ‘defended’ subject. This implies that each person brought their particular psychosocial history to their work and to the interview. Hence their unique experience and inner defences against anxiety coloured how they responded to the interview.

My intention to seek willing volunteers for interview was discussed and accepted in my initial negotiation with each team. They understood the interviews would follow an initial period of observing and would provide an opportunity to expand my understanding of the team’s work.

Testing out the method

Before submitting my proposal I wanted to test out the use of interviews as a research method to analyse how social workers thought on the front line. I identified an experienced member of an Emergency Duty Team (EDT) and former colleague, who was willing to be interviewed following a duty session. Prompted by his notes, he talked about each of the cases that had arisen. I noticed that after each case he said ‘So that one went away!’ alerting me to his view of the primary task – to despatch referrals elsewhere.

The final case was a messy situation of a teenage boy from a secure unit in the care of his father. He was barred from visiting his mother and siblings. An agency worker had been engaged to check up on the boy during working hours. This had apparently involved the police and further raised the profile of the case. The duty officer had come across the situation three days before. But he had been given no information on relevant telephone numbers or emergency accommodation arrangements - let alone any wider plans for the boy. That evening the boy had his father’s permission to be out from 6.30 to 11.30pm but did go round to his mother’s house. The duty officer managed to speak to her.

‘She told me they had a huge argument and he smashed up the younger brother’s computer but he’s now left. So I thought – “Well...” Then I got a terrible headache myself. It’s terribly unusual for me to be off sick, but another mental health act

assessment came in at 10.30 and I managed to get somebody else to cover for me for three hours'.

He described how he could not face passing on the boy's case to the second worker but slept for three hours, officially going back on duty at 1.30 am. He then became increasingly uneasy as to whether or not the boy had returned to his father. A telephone call in the morning confirmed that he had.

The social worker described his anxiety at the lack of information and the absence of an allocated social worker for the case, the general anxiety around the boy and his family, the way the violence of the row had somehow temporarily but totally disabled him, and the repercussions for him if anything had gone wrong. As he spoke, he spontaneously thought of a way through the situation 'I should have rung the father back at 11.30 to see if the child was back. That's what I should have done.'

I found the material, which I presented to a peer group discussion group, increased in richness and density with every examination. His sudden debilitating headache deprived him of the ability to think. His honest acknowledgment that he could not bear to repeat the muddled uncertainties to a second worker reinforced his temporary defeat. This illustrated Bion's 'attack on linking' (Bion 1967). His use of the interview process with an unobtrusive but sympathetic listener appeared to provide him with the containment that allowed him to think clearly again. By having the space to put his anxieties into words the projected beta elements from the case were transformed into alpha elements and allowed constructive thought.

The uses other researchers make of interviews

Although Cartwright (2002) in his analysis of the psychoanalytic research interview based his thinking on the process being made up of three or four unstructured interviews, his theoretical model has valuable pointers for other interviews. He emphasises the construction of meaning that needs to take place between the interviewer and interviewee. He suggests that they have to co-construct a narrative around a particular focus in the interview. The interview cannot be about finding out 'facts' since they would have been subject to much personal revision and interpretation. Rather the material in the interview relates to how each reconstructs a happening - the interviewee in the telling of the narrative, and the interviewer in their interpretation of it. This interpretation provides a valuable vein of exploration in considering the uniqueness and difference in the way that interviews unfolded.

Cartwright assesses the value of taking note of the fleeting transference and counter-transference impressions in an interview. He uses the term 'observer bias' to summarise the 'motivations, feelings, conflicts and perceptions' (p221) that an interviewer should recognize to understand what took place in the interview or to motivate her to undertake the research in the first place. Noting the thoughts and feelings evoked in the interviewer or interviewee during the interview, Cartwright suggests that 'reflecting on feeling states should become an integral part of understanding how psychoanalytic knowledge is co-constructed'. This suggests that we can gain insight into the construction of the interview through examining the transference/counter-transference traces we find. I noted these occasions during the data analysis and used the information to help to identify the 'emotional meaning' of the work for the team (see above Armstrong 2005).

Buckner (2005) illustrates this well when she examines the panel analysis of a biographical narrative interview which she has undertaken. In this we can see how her position as an unsupported and inexperienced action-researcher in an unstructured environment affected the interview which she held with the manager from whom she had sought help. The manager then told a 'public' account of her position in the organization as opposed to the rather different 'private' narrative which might have been told.

Hollway and Jefferson (2000) give examples of the researcher's background or gender clearly impacting on the process. They point out that an interviewer's experience of an upbringing in a large poor family allowed him to interpret the initial positive presentation made by the interviewee. On another occasion an interviewer is readily put into the role of 'mother' by the younger woman she is interviewing. While in 'The researcher talks back' (Griffin 1991) the author points out that 'of course you influence the respondent through stony silence or an encouraging smile' (p115). She goes on to describe her interaction with two interviewees. She felt it collusive if she did not tackle their attitudes to previous research, which she considered both sexist and racist.

Its advantages and disadvantages as a research method

The pilot interview had increased my expectations for the single research interviews. As well as hearing the preoccupations of the social workers about their working day, I hoped that the process itself might provide similar evidence in the here-and-now of 'a thought being born' - the active thinking which I witnessed in this pilot interview. However, there was only one such direct example (Jill's Tale at the start of Chapter 2). Did I under-estimate the role that trust plays in an interview? The pilot interviewee and I were known to each other. In contrast, although I deliberately placed the interviews in part 2 of my contact with the teams to allow more familiarity with the research presence, I still had to establish the interview relationship anew each time.

The semi-structured interviews with open-ended questions (see Appendix 4 p218) allowed for variation. The social workers spoke easily and fluently about their work and the working day in the team. The interviews also made it clear if they were professionally ambitious or waiting for retirement. This would not have been accurately revealed for example, by asking their age or expectations in a questionnaire.

The social workers themselves varied between the three teams in the way they wanted to use the interviews. The District Team members wanted to tell me specific things about their work – often with a sense of urgency. Several had ideas for change that would benefit the office. They may have used the interview to test them. The Hospital Team members, often in management or specialist roles, talked of the inter-professional work which they did, the problems of interpreting policy, and the complex systems to facilitate patient discharge from hospital. Some of the Mental Health team mentioned conflicts which they felt were unresolved. Members of all three teams provided lively detail on their approach to their work and the support systems available.

Sometimes I identified strongly with the interviewee's position and responded outside the researcher role (eg during interviews 7D and 8M). This role enactment (Odgen 1982) alerted me to the dynamics of the situation and led to further insights in the team. Modern technology made the interviewing process feasible. Use of internet search facilities clarified briefly mentioned procedures unfamiliar to the researcher, such as Fair Access to Care. A digital tape recorder allowed storage of the interviews on the computer. Voice recognition software speeded up the long transcription process. Any

part of an interview could be replayed to check against the transcript or to recall a tone of voice or hesitant phrase. The texts were then scrutinised and analysed (see data analysis below).

Locating the field work

I looked first for a willing team in the summer of 2004 while preparing the proposal. I met two social care managers in mental health who had responded to an introduction from a former colleague and my introductory letter (Appendix 2). They expressed interest but none of their individual team leaders thought that their staff had the capacity to take up the project. This alerted me to the perceived burden which a researcher could put on a team, and made me sensitive to future negotiations.

When I received ethics approval from the University of East London in December 2004, I sent the introductory letter to a former colleague, now a Director of Social Services, and suggested that any manager interested should contact me. The head of adult assessment and care management services responded. My meeting with her management group and subsequent agreement to work with both the District Team and Hospital Team is described in the Prologues of Chapters 4 and 5. I had to decide instantly to accept both offers as I felt to reject one and not the other would have a negative effect on the group. While this meant losing either the children's trust or the mental health team for my third placement, they did fill Waldo's category of 'normal' cases (Waldo 1962). Given the comparative lack of current research into district and hospital social work with adults this selection might prove an advantage. I might find something normally overlooked if I shone my torch into neglected corners of the field.

I attended a meeting of the region's mental health leads in social care in February 2005. One of the twenty five representatives shared my letter (Appendix 2) with her managers, one of whom expressed interest for their team. I had started my research in the District Team when we met in May 2005. The social workers' responsibilities for working with adults were less weighty than when working with children and families. This seemed to allow their defences to be more transparent. This confirmed an advantage of researching social work with adults. When this well-resourced multi-disciplinary team agreed to the research project (see Chapter 6 Prologue p121), it added to the diversity of the study, and allowed comparisons about thinking on the front

line in social work practice across a broad adult client range. This also increased the likelihood that the findings of the study could be generalised.

The three teams finally studied were similar in size and client group in the same inner city

District Team (D Team)
(April-July 2005):

An inner-city community social work team of 21 people in shared accommodation with another department. Staff worked with adults aged 19-64 with long term conditions such as Multiple Sclerosis or brain injury who needed help with daily living in the community or placing in sheltered housing or residential care.

Hospital Team (H Team)
(September 05; January-February 2006):

An inner-city social work team of 22 people based in a hospital, in the same borough as D Team. Staff were required to arrange services or alternative accommodation for people no longer able to manage without help at home, to facilitate discharge from hospital, and to free up acute beds.

Mental Health Team (M Team)
(April-May 2006):

An inner-city multi-disciplinary specialist community mental health team of 18 people, including 4 social workers, set up with a special grant 15 years ago to work with mentally ill homeless people.

Ethics approval

The need for ethics approval from the NHS (COREC) as well as from the University encouraged me to focus my research on the social workers and not to involve service users. The lack of their direct input was a potential loss to the research since service user input is increasingly valued. It created a conflict of values for me after actively encouraging service user involvement in social care research (Social Perspectives Network 2003). But the centralised COREC system was in its first months of operation. As it was more familiar with pharmaceutical trials than small qualitative research projects, it seemed preferable to avoid presenting too complex a proposal.

The process of submitting two ethics applications made me attentive to boundaries and to obtaining genuine consent to the project. Each of the teams had reached agreement to my involvement and attendance at meetings and duty sessions. I made it clear that

interviews were voluntary. Consent forms were given to those who agreed to be interviewed.

Developing trust and negotiating confidentiality

Since this research was neither participatory, with a close formalised relationship between researcher and researched, or emancipatory, with the participants co-constructing the research, I had to rely on informal communication to show my respect for the team members and to develop trust. There were several elements that made this effective. Large offices appeared to create an easier atmosphere than small ones, and my visibility reduced any paranoia in the teams. The presence of a link person provided team members with a clear negotiator and reduced uncertainty about the researcher's role. The ability to establish some stake in the environment, such as a chair to sit on, helped me to feel more comfortable.

Understanding the team's communication processes and ethos was helpful, as was being able to reassure team members that their working practices were acceptable. I was often asked to compare current practice with some past golden era – 'You must find the work we do so different?' I could respond that while an individual case may have received more attention, there had also been considerable inequalities in service provision. I was thus able to demonstrate a fair-minded approach in interactions with staff.

I asked advice of managers and social workers – how would it be best to go about something? I genuinely welcomed their help. I would ask if I could attend different meetings. If they were not happy, I accepted their decision. For instance, each time I asked a manager in District Team about the feasibility of sitting in on a meeting with a member of staff, they gave a good reason why that particular session was inappropriate. As described in the following chapters, my relationship with each of the three teams developed distinctive characteristics (see Fig 3.1 p46). For instance, at the end of the observation phase I asked Andy, the manager in D Team how he thought it was going. He told me that he had been asked just that by colleagues and had said 'Oh, its fine. Its just like Big Brother, you soon forget the researcher is there!'

In this document I have changed the names of all the participants while keeping to a culturally appropriate alternative. The descriptions of the teams have been made fully anonymous and the final draft of this document was shared with them. I shared the general findings with four groups of social work managers at a series of PQ workshops. They engaged with the concepts used and contributed further recommendations for practice.

How I analysed the data

I completed a three stage thematic analysis of the data: uncovering evidence in the data itself, using the literature I had read, and reflexively considering my own experience. The amount of data generated by the multiple-case study needed a robust approach. Taking each individual case I found that the selected research methods proved complementary. The observations in phase one, the participant observation visits and the interviews in phase two, and the researcher reflections on the counter-transference throughout provided opportunities for triangulation of content and information. For instance, several members of the District Team mentioned the noisy environment in their interviews. I was able to corroborate their perceptions through my own observations eg in Chapter 4 'Sitting in on duty'.

I had set out to find out 'what supported and what impeded thinking on the front line'. This provided a natural start to the data analysis. I used a qualitative data analysis software programme (MAX qda) designed to support the development of bottom-up findings, such as those used to develop grounded theory. I could cut the material in a variety of ways using different codes and add memos to capture passing thoughts and connections in order to enrich the analysis.

My initial coding covered all the incidents that appeared to support or inhibit mental space for the social workers from both interviews and observations. I coded all interactions either as 'supportive' eg asking and receiving advice from a manager or neighbour – or 'inhibiting' such as interrupting someone in the middle of another task eg the business manager while she calculated invoices. I looked at how they spent their time, such as concern about continuing care funding, or arranging accommodation and transport for a mother with no recourse to public funds. These codes produced visible and tangible surface factors that impacted on their thinking.

I sorted the material, drew clusters of what was appearing, and gradually developed and defined some bridging concepts. Through this I identified a further four areas in addition to my initial proposition of mental space that contributed to the thinking of the teams and creative capacity. I drew these areas out of the material and confirmed them through past professional experience and published research (Fetterman 1998)

Coherent policies (Hoggett 2006): I found that policies with 'high confusion' or 'high impact' most affected the teams' ability to think (Fig 7.5).

Professional development: I found this appeared to compensate for limited mental space in the team. Professionally motivated social workers made sure they had support, often through completing their Post Qualifying Award or further academic studies (Fig 7.6). They were ambitious, good networkers (Birchall & Hallett 1995), and a resource to their colleagues.

Mental space: I had set out to look for this, but was surprised at the variety of opportunities available eg 15 sites (Fig 7.7)

Autonomy: I knew from research (Balloch et al 1995) that social workers flourished with autonomy to make decisions and often wilted under autocratic regimes. The compliance demanded in the latter drives out creativity.

Support structures: the impact of the working environment on the social worker's competence and ability to think (Fig 7.8) has been written in many inquiry reports (Great Britain 2003) and in studies on decision making (Munroe 2002). I saw and heard much in this area.

I had suggested in my proposal that in addition to surface matters (identified above), emotions could occupy mental space and inhibit thinking. These could limit the ability of social workers to make good decisions and take appropriate action. This was a complex area of analysis. The evidence was often from my own feelings and reactions which needed careful scrutiny. I therefore drew out from the data all incidents relating to the reactions of the teams to the observer, coding them first as including the observer or excluding her. I noted and made memos with the software of the 'stray thoughts' (Bollas 1987 Ogden 1999) that had come into my mind while observing, and the times when I had found myself caught up in 'role enactment' (Ogden 1982). Some of these were evidence of counter-transference from the team. Some no doubt were subjective. But they all provided insight into the teams' areas of concern and unconscious preoccupations.

I built on this by drawing out the different metaphors team members used in describing their work. I reasoned that these could reveal the 'unthought known' (Bollas 1987) of team assumptions, experience and attitudes. These reflections crystallized (Fetterman 1998) my insight into the unconscious of the teams (see Chapter 7 Depth issues) – eg reflections on the District Team's watery similes when they referred to the fear of being flooded by work and the need to clear blockages, the production line mentality that enabled the Hospital Team to move dependent people to unfamiliar surroundings, or the Mental Health Team's denial of differences due to an unconscious fear of being ostracised by the group.

Analysing the depth issues demands personal commitment, humility and responsibility (Bollas 1987). Fetterman (1998) describes the process of a researcher's creative thinking as

'the researcher synthesizes ideas and often makes logical leaps that lead to useful insights. Such unexpected insights are often the result of allowing the mind to wander and consider unusual combinations of thoughts. The researcher must of course backtrack to see whether the data will support these new ideas or invalidate them, but he or she will rarely achieve them through linear, methodical work alone' (p 11).

I was particularly helped by the seminar studies. The insight of colleagues was perceptive, accurate and often new (Skogstad 2002, Cooper 2007 unpublished). It tested the integrity of the material and added to my understanding. For instance one colleague questioned my interpretation that a manager was reacting responsibly to a hospital request, pointing out the compliance and avoidance contained in the decision. This opened up a new area of thinking which illuminated the way that group avoided conflict (see Chapter 6). To understand and experience the unconscious emotional meaning of each case rooted the findings in a crystallization of ethnographic and psychoanalytic understanding (see Chapters: 4, 5 and 6).

I wanted to understand more about the cases which social workers found difficult in my pilot case study - D Team. I coded all the attributes mentioned and drew out categories. I found that all fourteen cases had three elements in common: multiple agency involvement, service user as victim, and individual or family pathology. Eight of the fourteen shared additional attributes of fraud, deceit, or suspicions of abuse; while the final six clients also attacked the social worker through actual violence, threats of violence or major complaints. These elements are similar to those exhibited by people

with borderline personalities (see Chapter 2, Fonagy 1991) or exceptional vulnerability. They formed a significant part of the workload in the team and occupied considerable mental space, requiring social workers to address unacceptable areas of human behaviour. There appeared few additional resources to process this sort of work.

In contrast, the clients in the mental health team were homeless and prone to psychotic breakdowns. Most had borderline personality traits or personality disorders. The team were well resourced and managed to handle the work. But the cases they found demanding were those with a difficult decision to make, sometimes in conflict with other professional colleagues in the team. This finding highlighted the team's issue about conflict and the need to understand what this meant.

I used methods suggested by Yin (2003) and by Miles and Huberman (1994) to marshal this information effectively and to allow the reader to compare the three teams, providing the meta-analysis that allows case studies to be generalisable (Jensen & Rodgers 2001). They demonstrated the advantages of presenting information through matrix displays and tables (eg Fig 3.1 p46). I was able to avoid repetitive prose by using single tables (see also Figs 7.1 p145 and 7.4 p157 to 7.7 p174). It was then feasible to display visually the contrasts between the teams in each of the enabling factors (see Figure 7.8 p177).

The extent and limits of the data

This multiple-case study covered three social work teams. The collection and analysis of the data and the research findings were well evidenced. While it was handled by a lone researcher, modern technology enabled me to increase the interview material available for analysis from the 18 proposed to 37. I made a total of 44 visits of which 18 were fully recorded psychoanalytically informed observations. The accuracy of the transcripts was high due to the ability to cross-check against the original recording stored on the computer. As in all field research, the data was dependent on productive relationships with the participants. This demonstrated the confidence the participants had in the research process. The analysis was stringent and the comparative findings are capable of generalisation.

I took a reflexive position to the research which enabled me to acknowledge the effect of my gender, race, age, maternal status and class. The gradual process of engagement at each level of negotiation by a senior manager, a team manager and then by the whole team helpfully allowed for checking and cross-checking of how differences could be managed. Only the District Team took up my offer to bring the preliminary findings to a team meeting, though the other teams had that option. For instance the Mental Health Team manager remained in touch over the following year.

Subjectivity was present in the Hospital Team placement. I have never been at ease in a hospital environment. It was understandable that they should express their ambivalence by not providing me with a space, particularly as they were encouraged to move people on. I needed to take up my authority, discuss the issues with the group and ask for possible solutions. Instead during the placement I had – through chance – to manage in my own life the unspoken group issues of death, disintegration and the need to hold things together.

The combination of observations, counter-transference experiences, and interviews allowed me to explore some neglected areas in the frontline of a social work team. The attempt to analyse the findings from a depth perspective as well as from the surface has been challenging and preoccupying and is inevitably more speculative.

Researcher support

I received excellent institutional support on a taught doctoral programme. I had regular monthly meetings with my supervisor and the seminar group. This gave the opportunity to share the analysis of the observations with two colleagues as well as my supervisor and head of department. Together we unpicked the counter-transference elements in each of our texts. Discussion of detailed written records in a seminar group provided many levels of insight. We were joined on two occasions by former students from other universities who had recently obtained their PhDs. It was illuminating to hear the different ways that they had approached their research.

I was able to participate in regular research conferences held by the institution which were stimulating and supportive. The informal friendliness of the research participants also proved supportive, reducing my feelings of strangeness and alienation.

Conclusions

In this chapter I have described the research design selected, and the theoretical foundations of the research methods used. The multiple-case study provides a clear framework for the research exploration. I explored the contribution of infant and organisational observation to the observation method. I concluded that the psychoanalytic perspective enriched the method. Recent views were examined on the value of counter-transference as an indication of a team's unconscious emotional issues. My feelings - or counter-transference - highlighted the need for emotional integrity to ensure trust with those being observed. I considered the use of interviewing as a research tool.

I describe my engagement in the field and how I analysed and categorised my findings. The observations provided data on surface issues and depth issues, corroborated by the extensive interviews. Consideration of counter-transference material showed some of the unconscious factors in the teams such as the emotional meaning of the work. In practice the interviews were welcomed by social workers, who used them in some cases to solve specific problems.

I found that by interviewing all the staff in the District Team as a pilot, they were all 'held in mind' by the research. This freed them up to make changes. This was not the case with the other two teams. The thematic approach to the data provided a coherent analysis of the findings, described in the next four chapters.

Chapter 4

The District Team (D Team)

Introduction

This chapter explores my experiences in the District Team (D Team). I introduce the team in the prologue, then describe an afternoon's duty. I have numbered the paragraphs for ease of reference. I comment on what I saw and heard and reflect on what it might mean for the staff and service users. Rather than write these comments underneath each descriptive paragraph, I have inserted them at two stages: half way through the record and at the end.

The chapter examines the two emotions that informed the primary process - fear and impotence. I wondered how they affected the way the team went about its work. I consider what helped their thinking and what hindered it. I analyse how the team used the research interviews (listed in Appendix 3) to 'unstick' its own processes. This led to change in the team's capacity to think about the work.

Prologue

The research proposal caught the principal officer's imagination. The summary (Appendix 2) had prompted her to wonder how internal personal traits, external demands and the ethical dimensions of the work might affect the way social workers went about their task. She managed three borough-wide adult social work teams – the District Team which dealt with younger adults (aged 19-64) and some complex family problems; the Hospital Team, which was under most pressure; and the older adults team, which was the busiest. They were all under such strain they could not take another 'drip'. She was interested in the research proposal for three reasons: it made few demands on the social workers; it was unusual to have someone interested in seeing actual work; and the research might help the social work field in the future.

At her management meeting I described my ideas about the project. Leroy, a team leader from the Younger Adults team, responded that no-one had ever visited their team or knew what they did. He thought they would be interested in helping. After

meeting the team they invited me to do the research project and spend the morning in the office with Andy, the manager. The team was based at the far end of the borough in a large first floor open plan office. Six officers from another department sat at one bank of desks in the room. There was a shared reception and interviewing rooms on the ground floor.

Andy explained that most of the team's work related to assessments for the provision of care services. After authorisation, social workers arranged the delivery of the care plans with one of the agreed providers. A review visit took place six months later. A second strand of work was the need to set up services rapidly on behalf of the hospital for 'Band One' cases. These were patients with a terminal illness sent home from hospital for the last weeks of their lives. A third area of work was the provision of temporary accommodation for destitute people with a health issue who had 'no recourse to public funds'. This was time consuming and contentious.

The people in D Team:

- Andy –service manager;
- Annie – operations manager (maternity leave)
- Sonia and Leroy - team leaders
- Mary – business manager,
- Rich and Sara (left on maternity leave) – admin
- Tony (HIV), Hazel + Clare (maternity leave) – senior social workers
- Dominic, Fiona, Jill, Kath (locum, left), Laura, Liz (locum, left), Marlene (locum), Peter (new), Sylvia (HIV), Valerie, Vivienne (returned), Yvonne, Kevin-Direct Payments Officer

I made sixteen visits between April and July 2005 - which included a briefing session, two team meetings, a teatime talk, and two half days on duty. I interviewed twenty people: the whole staff group except the Direct Payments Officer. I returned to give feedback on my findings in October 2005 (see Appendix 3 p217).

Sitting in on Duty - Part 1

Friday afternoon. An observation from 1.30 to 5.15pm

By the time I came to sit in on Duty I had met most people and gained a reasonable idea of the work flow through the system. I had learnt for instance that Duty was telephone based, given their position at the far end of the borough and their chronically sick and disabled user group. The three administrative staff took turns to spend the day as 'duty screener', handling all telephone calls and screening those that could be easily redirected.

The duty senior (a role shared between the two team leaders with occasional help from the senior social workers) took all referrals, spoke to the referrers and made any necessary telephone calls to the service user and other agencies. If a visit was needed to assess the requirement for a care package, they judged whether it was an immediate task for the duty social worker or could be done in the following few days. The duty social worker helped the senior make telephone calls to deal with current cases.

What could I learn about the team's main task by spending an afternoon alongside their Duty system? I expected the afternoon to contribute to my knowledge of the key variables of social casework (Perlman 1957): who were the clients? What were their problems? What processes were used in this particular agency and office? Given my background in organisational development I also hoped to begin to identify the emotional experience of working within this team and the implications for the organisational task (Hutton, Bazlegette and Armstrong 1994).

During the afternoon I absorbed the office's atmosphere. I felt what it was like to sit, expectant and vulnerable, ready to listen to the anxieties of the local community.

1. 1.30: The office was sunny, quiet and almost empty with perhaps half a dozen people dotted around. Dominic was preparing to go out, but seemed concerned about missing my visit. I explained that I had come in just to sit in on duty, but that I planned to arrange interviews with everyone who wanted in the next few weeks. This reassured him. Kath said she was the duty social worker and that the others were all at lunch. I pulled up a chair by the duty senior's empty desk at the adjacent bank of desks to hers. Andy, the manager, was sitting nearby, going through some papers.

2. Kath told me she and Marlene had been on a visit that morning but found no-one at home. She then called Sonia over to ask for advice on a computer form. Andy was looking around for some other papers. Sara, who was the duty screener that day and heavily pregnant, found them in the basket. As she handed them over she said 'you'll miss me when I'm gone!' He put them on Leroy's desk, sat back to continue his work and sighed. Sara told Kath and someone on the telephone how worried she was about getting her disabled mother to the airport.
3. Andy called Sonia over. She stood by the desk and talked about a letter he was holding. They had an assertive discussion for about ten minutes. Sonia was not backing down. I overheard him say that if the child was younger, the mother could be classified as a nursing mother and become the responsibility of children and families. Sonia said she still wanted to know the correct procedure, so that she could give correct advice when she was on duty.
4. 2pm: Rich, the other administrator, was emptying files from a box and putting them all by the duty desk instead. Leroy returned from lunch to continue as the duty senior. All seemed very peaceful. Sara said 'Whenever visitors come - like the study they did monitoring the telephone answering - it is always quiet.' There was a sudden rise in decibels as Liz came in and talked to Dominic behind me.
5. Kath was on the telephone while Rich told Leroy about a childcare request: Mrs Y had asked the home carer to collect her children from school. They had rung the office for advice. Leroy told me the office had commissioned an hour and a half's home care Monday to Friday to help her around the house. He rang Mrs Y and had a courteous but firm conversation with her. He explained that these carers were paid to help her in the house, and that they were not allowed to do child care tasks - only the carers from Children and Families were authorised to do that.
6. It turned out that Andy and Sonia were discussing a request from another borough for this office to accept responsibility for a mother and child (Mrs H). She had been an asylum seeker here and had fled to a women's refuge in the other borough. Her residency at the refuge had expired and she was now about to be evicted. Liz then joined in with Sonia arguing whether the child was a 'child in need'. I wondered if they were working up a case to pass it to the Children and Families Division. Andy explained that under section 52 they would have had to split the family, leaving the mother on the street as an illegal immigrant and taking the child into care. He was relieved that this had not yet been implemented. Andy explained that the legal department had advised they must take on the case.
7. Sara leant over and said that Mrs Y had rung back and cancelled the care service, because she intended to commit suicide and would not need it. Leroy spoke to her again emphasising that his service could not collect children. He sounded supportive but clear. She made her threats again and put the telephone down.
8. Sara now had Johnny on the telephone about Will. Kath and Marlene had missed them that morning because they had rung the wrong doorbell. Leroy wanted them to go again to find out Will's needs. Kath said, unhelpfully, that his needs were recorded on the file. She did however ask Sara to tell Johnny that they were discussing this at the moment. When Sara put down the telephone she remarked how friendly he sounded.

9. Meanwhile, there was a line-up of staff to protest to Andy about taking on the 'no recourse' case while Leroy was insisting Kath made a visit, as he wanted to know about Will's situation. Marlene joined in that debate, asking if Will had Korsakoff's psychosis or alcoholism. Kath called Johnny back to ask him. He said that Will became confused. Leroy continued to push for a visit so Kath cleared with Johnny that 'if we ring and tell him we are there and give him time to get the door, did he think it would work?' She also acknowledged what hard work it was for him looking after Will.
10. Sara now had an assessment of a woman with cancer whose husband has been caring for her – she was back in hospital. Leroy rang up about a referral from housing about Mr and Mrs Z. They had been worried about the wife who was in a wheel-chair with a degenerative disease, but her husband would not let anyone in the house. Leroy told me that when they had offered an assessment, Mr Z had refused it. While they were wondering what to do, he had had a massive heart attack. He was now in hospital, severely brain-damaged. He was only thirty eight years old. Their eighteen year old son had left home and could not continue to care for his mother. So they needed to arrange emergency respite care for her.
11. Kath spoke to Will on the telephone. Marlene agreed to go again with her, saying they would be there in thirty minutes. Leroy said he wanted a short assessment, while remarking to Sara, 'what will we do without you?' Marlene negotiated that they would go straight home after the visit, given the travelling involved.
12. 2.35pm: There was a lot of laughter and noisy conversation from the group at the HIV desks where Tony, Sylvia and Jill were sitting. Kath used the time before leaving to try and trace a client who had moved from bed and breakfast accommodation. Leroy dealt with another call. He advised the caller to tell the person about whom they were concerned, to go straight to the DSS and obtain a crisis loan before it closed at 4pm. Although he was sure we knew that client, nothing came up on the computer. He advised the caller, if the person was depressed or distressed, to take her to the GP first thing. He reassured them that she was very likely to have accessed other services.
13. Kath and Marlene left for the duty visit. Leroy explained that Marlene needed to accompany Kath because a red flag has come up on Will's case. This required two workers. The decision to visit influenced the use of resources for the rest of the afternoon. They were now unable to see a woman who was deteriorating, and needed a new assessment for an hour and a half's help for a week.
14. 2.45pm: Andy approached Liz about her caseload. She said that most of her cases involved social work visits and not just reviews. Andy returned to Leroy to negotiate an assessment and accommodation for seven days on the 'no recourse' case (Mrs H). He knew that Leroy thought they should not accept the case because he did not trust the solicitors.
15. Andy then stood by the printer at the end of the duty desks and saw that someone had tried to find Yvonne's General Election results. He explained to me - and the world at large - that there were mixed feelings about her standing as a Conservative candidate. He did not want to lose another member of staff as two had left since Christmas and Sara was off the next month. Nor did he want a Conservative gain. However he hoped that she had done quite well. Andy walked over to Rich, and the two men had some sort of teasing conversation with Sara. Then Andy leaned over the printer again in a relaxed manner.

A reflective commentary - Part 1

When I arrived the office had a quiet and containing atmosphere. Individuals looked purposeful: reading files, completing computer records, and planning appropriate action (Paragraph 1). Dominic indicated that he was eager to be interviewed as part of the research. Andy was sitting in the main office to go through papers, rather than at his own desk. He had moved from his office to enjoy the company.

Kath was friendly and inclusive towards me by updating me on her wasted morning visit (2). But there were signs that the completion and monitoring of computer and paper records made many demands. She needed a team leader's advice to complete a standard form and Andy could not put his hands on some files.

Sara's fecund figure (2), and her plans beyond the world of work, represented the potency not only of parenthood but of the ability to be in charge of her own affairs and destiny. This was in stark contrast to the team's service users whose own futures had been put in jeopardy by accident or illness. They either lacked the physical ability to take independent action or the mental ability to arrange this. Andy's sigh, after Sara's reminder that she too was leaving, alerted me to the heavy burden that had resulted from all this fertility.

Andy and Sonia were deep in discussion (3) over an apparently confusing piece of policy. It sounded a contentious situation.

Rich's further boxful of papers (4) signalled there were a number of different places where the office papers could be found. Sara's comment on the quietness was almost wistful, as if busyness would be more acceptable for the research. Liz's noisy entry (4) was quite a shock. I was startled by the contrast between the peaceful room, almost the sense of Winnicott's potential space, and the abrupt noise. I felt rather like an infant being woken from a day dream by a sudden noise.

Leroy's conversation (5) with Mrs Y reminded me of similar conversations which I had held in the past with 'problem families', when required to set boundaries in a reasonable almost parental manner. It made me feel quite at home.

Andy, Sonia and Liz's debate over Mrs H (6) was rather open-ended. Andy's reminder that the government had passed legislation to split families seeking asylum was a shock. I remembered that homeless families had been divided in this way before the introduction of the Children and Young Persons Act 1963. Current legislation seemed harsh and retrogressive. If introduced, Section 52 would require public sector employees to act against the welfare of the child and their consciences.

Leroy's calm manner on the telephone (7) suggested Mrs Y was well known to the Team. She might have been one of a number of service users who easily became angry or hysterical at the unexpected, fitting Mattinson and Sinclair's (1979) 'problem family' description. Kath was clear that it was not a priority to make a return visit to Will on a Friday afternoon (8). She disagreed with Leroy's decision that they should visit again. However she appreciated the difficulties of his carer, Johnny, and acknowledged his concern (9). Sara's positive comment on his friendly manner was also an encouragement to visit.

There were now three situations taking place, any one of which demanded thoughtful care. Leroy's ability to contain the anxieties of referrers, service users, and staff, was a major factor throughout the afternoon. The ability to prioritise accurately and think carefully was essential, faced with a hysterical mother, a brain damaged alcoholic, and a destitute mother and child - all needing attention. The duty screener Sara underpinned the operation by taking telephone calls and passing on information which Leroy acknowledged and appreciated (11).

I felt a twinge of sadness for the husband whose wife was failing fast and who had made the effort to let us know (10). This was quickly displaced by the shocking reminder that heart attacks and strokes are not just the lot of the very old. Here was a service user aged thirty eight with severe brain damage and his disabled wife - mentally alert but physically unable to care for herself.

There was also a sinister undertone to the work. Why had Mr Z refused anyone admission to the house? What was his relationship with his wife? The primitive notion that his heart attack was some form of retribution crossed my mind. Again, Will (9) was a chronic alcoholic with brain damage. The red alert on his file (13) indicated he was potentially violent and abusive with it too. Mrs Y, whose need for help and assistance had been recognised, had made two hysterical threats of suicide during the afternoon. Mrs H may have been mentally competent. But as a destitute person she had no voice in the plans being made for her, and we were uncertain as to her motivation.

I was also aware that I was gleaning the smallest of fragments of information snatched from telephone conversations, discussed over my head or heard from the other side of the room. It was surprising to realise how vividly I could construe a story on such little evidence as with Mr Z above (10).

I was amused at the canny arrangement Marlene made with Leroy (11), which compensated them for their second visit to Will. It also indicated the distance of the office from the majority of service users' homes.

The small group of social workers talking and laughing (12) were very distracting. But perhaps the wider group needed some distraction. Certainly no-one intervened to curb them. Perhaps there was pressure to provide vibrancy and life, though occasionally with a manic tinge, to contrast with the passivity and depression of chronic illness and disability. Leroy's telephone manner was consistently calm and reassuring (12). This gave me confidence in him and the system. He was sure that we knew the person being called about, and could confidently reassure the caller that they had accessed several forms of help. I was reminded of the advantages of a stable staff group, which allowed this sort of knowledge base to develop.

Liz had been recruited as a locum to bring the team's six monthly reviews up to date. She found many of the clients had further needs (14) which she had then taken forward. It seemed that her progress in clearing reviews may have slowed. I wondered if Andy's careful handling of Mrs H was due to his awareness that Leroy would scrutinise his actions particularly carefully as he disagreed with the decision.

Andy seemed ambivalent about having a member of staff standing for Parliament (15). Indeed I found the whole organisation was ambivalent about staff development, ambition and advancement. Perhaps the team, working with chronically ill and brain damaged people, performed a useful role in the wider organisation. They could be the ones who were 'stuck', so that others could shine. The joke that he and Rich shared with Sara may have helped diffuse some of the tension which built up during the negotiations over Mrs H. This crystallised when contemplating Yvonne's unwelcome boldness in standing as a Member of Parliament.

Sitting in on Duty - Part 2

16. I heard Jill ask Kevin for advice and information on the direct payments form for a duty visit she had to make. There was a general conversation about Mrs H competing against a radio playing in the background. They talked of a threat of JR (judicial review). This would be on ordinary residence. Although being a 'no recourse' case it did not have to be done here. Andy thought someone should ask the asylum seekers team to make some arrangements by Monday.
17. He told Leroy that we needed to assess the case. He thought that he would hand it to Tony. I was unclear on implication of 'ordinary residence' and their conclusion about the case. Leroy told me he was annoyed that the council lawyers had given in to the other borough, because these cases were a potential limitless drain on resources. I saw Andy take the papers and ask Tony to do the assessment.
18. As the telephones were quiet, Sara had started tidying the cupboards and checking the in-tray basket. Leroy noticed that I looked sleepy and patted me on the arm saying 'Now you're not to go to sleep on me!' I think they were worried that it was not busy enough or that I was bored. So I made us a strong tea and coffee. The trees outside the kitchen window looked beautiful in the wind and sun. When I returned Sara was asking 'Why do they go on so on the telephone?' Leroy replied 'to get rid of their anxieties on to you!'
19. Andy walked over to confirm that Tony had agreed to assess the case. 'So if the senior lawyer rings, tell him that it is seven days accommodation with no prejudice and categorised as domestic violence and no recourse.' Lloyd told me that the assessment was to consider Mrs H's long-term future. Liz argued 'She doesn't have to come back to a violent environment. Why not stay in x?' Leroy repeated 'We have to assess.' I looked up to see Andy and Liz looking through a garden catalogue discussing types of fences.
20. Rich then answered the telephone, and there was real pleasure in his voice when he said 'I'm afraid you need the over 65s team'. Andy and Leroy had a short discussion about booking in a review and the need for formal decisions on the cases left by the HIV social worker. Andy and Sara continued to sort out the cupboard. 'Where are the books we bought for our library?' he asked. I fetched a glass of water and returned to find Tony sitting in the chair and talking to Leroy, about the action plan for Mrs H. Tony

would tell the other borough that we would take on the case and would do the assessment on Tuesday.

21. Leroy continued with his paperwork and said that I had missed a feisty exchange with the hospital discharge people two days ago. A care package had not been logged onto the system. As this office only paid registered invoices, payment had been refused. Both the hospital and emergency duty teams occasionally forgot to record care packages on the computer system. This particularly annoyed the team.
22. Tony called over that he had found a self-contained studio nearby for seven days from Monday for Mrs H and her child. He asked Leroy to tell the Legal Department. Andy leant over the printer. He was talking about Occupational Health and his bad back, saying that once a year it was so excruciating that he could not even walk. Leroy described his mother's back operation and everybody talked about their backs until the telephone rang.
23. Liz brought some case papers to Andy and asked for a copy of the letter that was used in lieu of the care plan in residential nursing care. Sara said, 'I wish someone would do a list of all the letters we are now meant to use'. Liz said Anna would know. Andy interjected, 'No. Don't ask her. She is under too much pressure - ask Dennis' (neither of whom were based in this office).
24. 4pm: I began thinking 'Only one more hour!' Leroy rang back a client who had had a frame removed from her leg and was worried about weight bearing. The referrer had noted that her parents had moved away which implied she might be still dependent on them in some way. Leroy asked her if she was having physiotherapy. Could she manage personal care, house work and cooking? When these were all answered in the affirmative, he suggested that she should see how she went. If she was not getting better we could consider services in the home. He explained to her that it was not an urgent situation, but if it became worse she should contact the team. It was a reassuring interaction.
25. Kath rang in from her visit to Will and Leroy returned her call saying, 'Oh, that's good'. Simultaneously Liz talked noisily to Sara and Rich over my head. Kath had come up with an action plan: providing care for the basics with a referral to mental health being likely. 'Just what I've is going to suggest' said Leroy.
26. Tony came round and thrust a flyer in front of me. He was raising money for a charity walk. I signed up and handed him what seemed to be the standard donation. I thought this advisable before sitting in on his duty on Monday. Leroy was pleased with Kath's visit and told me that they done a good assessment. He had wanted them to see Will before the weekend, and now they could go home.
27. 4.15pm: The home care providers rang to say Mrs Y had left the house. The carer, who had been there for the hour and a half, did not know whether they could leave or not. She had gone to collect the children. Lloyd advised that the carer should write a note and also return on Monday as Mrs Y was rather volatile and not good at thinking. He said to me that this work was unlike child care as adults could make their own decisions.
28. Someone rang for Andy but he had gone to Occupational Health. Sara found that the service user mentioned was allocated to Dominic. She gave the caller his telephone

number. She mused as to why everybody always wanted to ring the boss. She told Leroy that Tony had handed back Mrs H's 'no recourse' papers as he had not yet done a referral sheet on the computer.

29. 4.30pm: Rich walked past to the back of the office and asked Kevin for a list of all his active direct payment files. Kevin agreed and Rich walked back. I thought 'How easy!' Sara called Leroy saying 'It's the legal department about Mrs H'. She then spoke loudly over his head to Liz. Leroy explained to the Legal Department that they would assess on Tuesday, and that the lady should be told to come into the office at 10am on Monday and receive details of the flat. He then continued to write up cases.
30. Sara's mum rang to tell her that people were viewing the property at 9am the next morning. Leroy told me that it was bad case law, like the 'no recourse' cases, that fed the Judicial Review system. Meanwhile the council's legal group advised them it was cheaper to give in and provide accommodation since each challenge risked costs to the council of thousands of pounds. This meant that solicitors regularly bullied them to agree to their clients' demands by immediately threatening them with Judicial Review.
31. Sara asked Leroy what had happened to Will and Johnny's case. As the clock reached 5pm, Leroy asked me if I missed social work practice, or was I happy as a researcher? We chatted about some of the changes that I could see: more legality, more responsibility and more resources. Within a couple of minutes of 5pm the office had emptied. Leroy told me he liked to stay to make sure everything was tidied up.
32. He then remarked that while there were many good things in the system there were greedy people who manipulated it. He called Liz over to tell me about a case in point. She described a council employee who had taken long term sick leave during which time she got a first class degree, a husband and a baby. She was now demanding to be rehoused with 24-hour care.
33. Sara told me she was selling their house as she and her husband were moving to Cornwall along with her mother. It had taken her dad's sudden death to jolt them into action. For example her sister had now gone to live abroad and her other brother was already in Cornwall. I gradually gathered myself and checked with Leroy what time duty started on Monday. He suggested that I should arrive between 9 and 9.15am. I wished Liz, Sara and Leroy a good weekend as Leroy shook me by the hand.

A reflective commentary - Part 2

Staff had initially found the government's Direct Payments policy difficult to implement (16). The take-up had increased by 50% following the appointment of a specialist officer, who was initially seen as peripheral to the team. Perhaps social workers were reluctant to adopt another new system or were anxious about being blamed for fraudulent claims.

The complexity of 'no recourse' policy was further discussed, absorbing more energy and time. The Judicial review system was being misused by some solicitors to hold

public bodies to ransom. This could not easily be changed. Leroy seemed to feel that they were being ridiculed by legal practitioners (17).

It was interesting how quickly Leroy sensed that my mind was wandering (18) and brought my attention back to our different tasks. I think this indicated an unconscious awareness that my attentive presence provided a function for the team – perhaps as a temporary container. I was aware as I admired the trees from the kitchen that they hid the cemetery from view. I thought how the team too hid considerable damage and disturbance from wider society.

When Leroy explained the telephone transactions to Sara (18) saying ‘they are getting rid of their anxieties on to you’, he seemed to be describing the team’s broader function in the locality. It was a good example of ‘teaching on the job’ when experienced staff demonstrate good practice and act as a role model to others.

After the climax of accepting Mrs H (19), which Leroy acknowledged with professionalism and good grace, Andy and Liz started to choose garden fences. Perhaps they wanted to improve the team’s boundaries and defences against future incursions.

Age provided the team’s only simple boundary around service provision (20). Rationing via the eligibility criteria (Great Britain 2003) took longer as it demanded assessment and judgement. Given the team’s reluctance to recognise that the Operations manager Annie had left for an undefined period of maternity leave, I was impressed to see the two managers tackle the caseload of a social worker who had recently left after prolonged sick leave. The mislaid books (20) seemed symbolic of the ease with which expertise and potency in the team could be mislaid.

In (21) Leroy used the memory of a victory over the hospital discharge team to reinvigorate himself after the defeat over Mrs H. The council appeared to have set up a devolved accounting system that made conflict inevitable. Perhaps the disagreements represented a safe discharge of energy and pent-up annoyance.

The conversation that Andy generated about bad backs (22) drew in everyone in an engaging and almost seductive way. It possibly reflected the burden of the anxieties

and expectations carried by the team for the community. Unexpressed emotions were likely to produce physical manifestations unless there was a regular verbal acknowledgment of their role which helped to translate the weight of these expectations into words.

There was no single individual in the team who kept in mind the numerous different forms which had to be completed at different stages of the care management process. It meant that everyone was uncertain of one procedure or another. For example Liz (23) had to telephone different people at other offices to find an answer. This undermined the ability of staff to carry out tasks promptly, leaving an increased number of tasks to be remembered later and increasing mental strain. While Sara longed for a list of all the forms, it did not cross her mind that as an administrator she could start the process.

I was clearly finding the afternoon demanding, and noted the steady but slow progress of the clock (23). The service user had been presented as vulnerable in some way, so Leroy used the telephone conversation to check this out. At the end they were both reassured that she was managing her daily life.

By telephoning Kath (25) back to hear about the assessment of Will, Leroy was not only following the office health and safety procedures but also giving her some undivided attention. Perhaps Liz felt envious, and her noisy exchange with Rich and Sara was an unconscious attempt to sabotage this.

Tony's demand for sponsorship (26) may have been less personally persecutory than it felt. It could have been his straightforward manner, as a few minutes later he somewhat surprisingly asked Sara to return papers to his manager Leroy for completion. By telling me what a good visit Kath and Marlene had done (26), Leroy was also expressing his relief that he had made the right decision in sending them out.

The debate over Mrs H may have had an impact on Leroy's handling of other work, for instance of Mrs Y. His feelings that they had been a 'push-over' were probably still in his mind. This may have reduced his capacity to pay more attention to Mrs Y. He described her to the care worker as 'rather volatile and not good at thinking' (27), but did not commit the team to further involvement.

Sara may have wondered (28) why people asked for the manager on the telephone. I was less surprised as Andy made every decision on resources. My reaction to Kevin being able to give Rich the information he wanted was partly due to my experience of home working. After several years working for a national organisation from home, the idea of walking over to a colleague's desk to obtain the information needed was refreshing (29).

Sara's imminent departure and her plans for selling the house (30) were intruding on the group, as was her pregnancy. Leroy explained the recent unsatisfactory history of the council's 'no recourse' work and inability to challenge rogue solicitors - another loss of potency.

I was surprised at the staff's rapid exit at 5pm. Then I remembered that my area team used to finish at 4.45pm on a Friday and leave with similar speed. Leroy waited until the duty day was over before engaging me in general conversation about social work (31). We were a similar age but of different race and class. To follow the values of ethnography, I considered it important to be genuine in my responses, and use the opportunity to 'de-role'.

I think that Leroy asked Liz to tell me about an extreme case of fraud (32) as they were finding it difficult to manage their feelings of outrage. Not only did they suspect the service user of exploiting the system, but she had taken a complaint out against them when challenged. It was interesting that one of the gains of the 'sick leave' had been to have a baby.

I continued to 'de-role' in a conversation with Sara (33). However I wondered how far her need for action after her father's death and the coming baby was an expression of frustration at the team's inability to take appropriate action around some of their systems.

On the journey home I remembered the rise and fall of sound in the room. It changed from purposeful quiet to noisy chaos in a split second. Just as a stroke or heart attack could suddenly render one senseless, so the din could attack one's thinking process. The other impression was the slowness of the glimpses of people's lives and the

team's activity that I had during the afternoon. I was positioned at the edge of their world just as they were always on the periphery of their service users' world. In both instances we have to strain every one of our senses to wring out the information if we are to construct a correct narrative from these limited fragments.

The aftermath

Conscious that my view of the lives of service users was even more fragmented and spasmodic than that of the social workers, I was pleased when I heard later bulletins on their progress. For instance, Mrs Z's situation re-emerged in my interview with Valerie a couple of months later. Valerie had completed the assessment for Mrs Z at the time of her husband's heart attack. She described the double-bind that was often present in cases of suspected neglect:

'When I saw her she looked very small and very under-nourished. She was not unkempt because I think the family had been able to manage her a bit. But when she was placed at the nursing home they said that she had no clothes at all that were suitable to wear. So I do not think her husband was looking after her very well. But that was her choice. Although in a sense she didn't have a choice, because he would not let anyone in. You can't do anything unless you can prove that the person is being neglected or is at risk so that you can use section 47 and get the police in. But that was not the issue when I saw her.'

That concern was now in the past. The current issue was to find a suitable placement. There was nothing nearby for someone so young. However the placement officer did eventually find a home within reach of the hospital and her family. This appeared to meet some of her needs:

'She is still the youngest person in the nursing home. But she gets on very well with the staff; she is quite happy with the support that she is getting from them; and they have taken her on several occasions to see her husband.

The other thing is that we are not sure what is going to happen. She wanted to return home but her husband is not going to be able to be her carer. The husband needs a residential placement. She has agreed that if that is the case then she wants to be placed with him. But this is not possible as they have different needs. So it's very difficult to see how we can work this out. We do not want to split them up. But it is also very difficult to find a placement where both of their needs are going to be met.

Her parents are very supportive. They want what is best for her. I went to see her last week but all she is saying is that she wants to be with her husband. I said to her "if it is not possible for you to be in the same place, but you could visit, how would that be?" She said that would be all right. Both of them are

young and that is a problem. It is very sad and difficult and practically very awkward' (Int 9D).

The shock and drama of Mr Z's heart attack had receded like the tide, leaving behind two people stranded, and now dependent on others for their care. Valerie's last sentence was a fitting statement for much of the team's work: 'It is very sad and difficult and practically very awkward'.

Mrs Y did not fare so well with her social work contact. She had been told on the next working day both by D Team and the Children's Team that she needed to contact the other, so had rung back in understandable confusion. Rich tried to find out how to amend the contract with the care providers. He discovered that as her carers were paid for by two departments, the departments needed to agree which was the lead agency. The lead agency would then have the power to alter the contract. Until they had agreed that – although it was unclear as to whom 'they' were - nothing could be done. Like Mrs Y, I was left unsure if anyone was going to help unravel this Kafkaesque muddle.

Two months later (Visit 13) I heard Yvonne ask Andy what she should do, as her telephone conversation to reassess carer input with Mrs Y had gone badly. Should she visit to assess her need for home care? Andy suggested she should ask the care agency for feedback on any problems and checked 'She wasn't horrible to you, was she?' Yvonne replied that Mrs Y had tried to be.

I longed to champion Mrs Y's need for some face-to-face contact rather than the telephone calls, which she appeared to find so difficult. Her outbursts may have affected her reputation as staff seemed to be wary of an assessment, just as Leroy had not pursued it weeks earlier. The continued use of telephone calls seemed a defensive action to ward off involvement.

What is the emotional meaning of the work?

Fear of drowning

D Team had inherited 250 pieces of unallocated work when the adult services were restructured three years earlier. It had proved hard to clear this completely. Managers

used vivid watery similes to describe their tasks eg 'to keep the work flowing' and 'to unstick any blockages'. They took seriously the danger of 'drowning' under a continuous stream of new referrals. They invested, as seen above, considerable resources in the duty system as a bulwark against the feared flood.

This practical emphasis on movement and throughput was perhaps in unconscious contrast to the situations of their service users, which were more likely to be drifting, stuck, or declining. It delivered what government policy considered was required by society with its emphasis on speedily completed care management assessments. This allowed the social services department to produce the required statistics for the community and the Department of Health.

After Annie left Andy delegated the responsibility for allocating new work to one of the team leaders. This coincided with some failure in the computer system. She therefore had to keep a manual record of all the cases to 'make sure nothing is lurking in the cupboard....we must prioritise the basket. We cannot leave cases lurking in there that could create problems for us' (Int 13D). Holding sole responsibility for all the incoming work, she had to develop rigid systems to avoid losing control of the work and being swept away in the rush of cases. She was particularly anxious that initial assessments should be accurate to reduce the incidence of fraudulent claims - one of those 'lurking' disasters. All questions on the assessment form had to be asked again, even if completed earlier by the referrer and duty screener. This impacted on the social work staff, where the lack of discretion contributed to their sense of impotence.

Her working day was dominated by the press of referrals. When asked if anything good was happening, she noted that three workers had taken on some extra new cases to help her over the holiday period. Her situation highlighted the lack of mental space for discussion. With Annie's absence she had lost a supportive supervisor, and the prospect of management training. There also was no time to consider alternative ways of organising the new work.

The team seemed to use denial too as a defence against the worry of their staff shortage. Annie's office remained unoccupied, as if she was still there, in spite of pressure for quiet space. Again, when asked who was in her team, Sonia listed six names, but four of them had either left or were on long-term sick leave.

Fear of being overwhelmed by the 'grot' in the community

Another fear was that the repressed negative aspects of the work might bubble up, like effluent from a sewer. They had to confront and manage the negative aspects of human nature and look under the surface. In the depths was abuse of vulnerable, dependent people or instability verging on madness. Indeed the team had to deal with 'the shit' in society both literally and figuratively. For instance, a man was discharged from hospital before care services had been set up. He was found after the weekend covered in urine and faeces (Visit 9). The undertow of child trafficking (Visit 9) and murder (Visit 12) was evident, as was the constant need to be alert to adult protection issues:

'She has a younger sister who didn't want to know them and was not interested in their life. That changed when she was awarded £1.5 million in damages. All of a sudden this other sister came out of the woodwork and has given up her job to look after her sister and mother. She now has power of attorney. Both mum and daughter are asking how they can get rid of her. The sister is saying that they are both mad. They accuse the sister of trying to take the money but she wants to get them put away in a home' (Int 14D)

Some care workers too were not above suspicion

'We managed to get him into a house. Unfortunately he got too attached to his carer and he gave her a thousand pounds to buy furniture. But there is something fishy going on. The carer refuses to bring receipts!' (Int 2D).

Occasionally the service users themselves, fearful of their situations and frustrated by their condition, were difficult to help

'She is now ranting and raving and saying that she needs night cover' (Int 16D);
'Then you find she's gone to the Town Hall and been giving you grief' (Int 2D);
'He was really rather intimidating and scary' (Int 11D);
'He's a challenge because he is so demanding. Whenever we put in agency help nothing is ever right' (Int 4D).

The activity in the office seemed to form a thick impenetrable surface, like ice on a pond or a heavy fire blanket. Was it to trap the repressed and unpleasant aspects of the work beneath the surface like a painting by Hieronymus Bosch? Is this where the undigested beta elements of thought were housed? Occasionally cracks in the surface appeared, letting some of the fears into the room, as when my neighbour exclaimed when talking about an asthmatic service user 'She might die!'

Andy told me of the rat he had found in his kitchen (Visit 8D). The dirty, evil aspects of life seemed to be breaking through the surface, with only the members of the team to shield the rest of the community. Was anyone keeping them 'in mind' or were they working alone and unacknowledged? The Department of Health admitted in 2008 that it kept no records of violence against social care staff. Was it surprising that staff themselves sometimes failed to confront such aspects of the work when these were avoided by the government department responsible for the service?

Impotence

This pervasive fear also left the staff with feelings of impotence. They felt impotent in the face of the mental and physical disintegration of their service users, the death of younger people, exploitive and unhappy relationships, financial restrictions, stringent eligibility criteria, and the organisational restructuring to reduce two layers of management. Over the previous six months the team had a succession of pregnant women staff, unavoidably displaying an alternative world of creativity and independence from work. This had stirred up difficult feelings for the team.

There was impotence, but also envy from those who would have liked to have been in the position of birth and renewal. This envy seemed to leak out into the team and limit creativity in the group. No space was provided for the group to discuss and solve its operational problems. Sara could have co-ordinated the forms (see paragraph 23 above); Rich was a skilled IT operator and could have set up a monitoring system for Sonia's new cases (above). He probably could have led on statistics and information as well.

There was little identification of development opportunities. Andy's ambivalence towards Yvonne's efforts to stand for Parliament may have been an expression of his personal view of her abilities. But it may also have been the organisation's view of ambition. For instance one day I found Andy preparing a presentation for the Commission for Social Care Inspection. He was surprised and pleased that the Assistant Director had a whole afternoon to talk about adult care rather than the usual five minutes. But when I asked if he was going to present the team's work, he was quite startled and said 'Oh no! Just the bigwigs do that!' (Visit 13D).

There was a continuing struggle in the team between this passivity and impotence and a desire for life and creativity. Leroy and Sonia had recruited competent and dynamic staff as locum social workers through careful search of internet applications. These locums had introduced a more hopeful energy into the group. This contrasted with the view of a few staff who had been on prolonged sick leave and appeared to be waiting to retire. They made it clear to me that they had no desire to undertake any development or training, or look to ideas of innovation or renewal. It was as if they had taken on the chronic and unresponsive aspects of their service users. Indeed one remarked 'If I get ill again I'll need my own care package' (Int 9D).

Unsurprisingly, the lack of delegation and autonomy was resented

'Many of us feel deskilled at the introduction of panels and not having any budget holding responsibility while we may have to make a decision about someone's capacity or the need for a placement in an adult protection situation' (Int 17D).

Andy had felt unsupported after the departure of his deputy Annie. When he needed affirmation of his competence and potency, his proposal to make a temporary internal promotion to cover the post was rejected. This was a serious blow to his morale, made worse by the move of Kath and Liz to permanent jobs nearer their homes. It seemed that the containing skin of the team was being sorely tried, and even breached by the unconscious and negative forces in society.

Two weeks later Mary reacted against this helplessness. Without waiting for permission, she recruited a locum administrator to replace Sara. She said

'It is terrible. The pressure on people is getting silly. People can't even speak they're so pressurised. Andy sits in his office saying "it's all falling apart." I say "Don't worry, we will try to keep it together".

When I asked for an administrator Andy said that it had to go to the panel for agreement. I told him "I don't care. I have to have that person. If I don't get someone then I'll get this pile of invoices, pack them up and take them to the group manager and say that we can't deal with these anymore". So I just went off and got somebody' (Int 6D).

Absorbed by these emotions and real staff shortages, the team had temporarily lost direction and potency. The managers had forgotten to use the usual structures to support themselves. They rarely met as a group. The senior social workers were

unclear whether they were actually part of the management team. There seemed to be no way to open up communication across the team. A single Away Day had been held eighteen months before, but there had been no implementation of the ideas and plans created. They could find no time to provide space for the group to come up with ideas that might help.

The organisation's primary task

D Team's service users had difficulty thinking for themselves, so the team's primary task was 'thinking for others'. Service users either had a long term condition that affected their cognitive and emotional thinking, such as Multiple Sclerosis or Parkinson's disease, or had brain injury through accident or alcohol. Some were thus physically and mentally dependent and at risk of exploitation or abuse from family members or carers.

Another group who had difficulty in thinking were those with a borderline personality. These service users often had difficulties in establishing and maintaining reciprocal relationships with neighbours, family and agency staff (Mattinson & Sinclair 1979). This showed itself through an avoidance of close relationships or alternatively as an anxious attachment, dominated by wild swings of love and hate towards those closest to them. Mrs Y, for instance, may well have fallen into this category.

Winnicott (1963 p227) talked of the social worker providing a 'facilitating environment' to 'facilitate maturational processes'. In recent vernacular this process may be referred to as 'empowerment', but that might imply substantial independence but with no supportive presence. Another term he uses is 'ego support' suggesting a temporary support - someone giving a hand and making the external landscape less hostile and the internal landscape slightly softer. We all need ego support at different times of our lives, viz: the care to which Hoggett (2000) refers.

The social workers in D Team aimed to provide a supportive and containing environment for their service users. By maximising the physical abilities of users, they reduced the invasive effects of worry and fear on the mental and emotional capabilities of the service users. For example, they provided help through home care or regular visits to a day centre, sheltered housing, aids and adaptations to ease daily living. I

was uncertain if help for a service user to effect a reconciliation with their estranged family, or for a carer to gain understanding of the way forward with a disabled partner were considered social work support, rather than 'counselling' or 'therapy'. I feared that these emotional aspects of physical problems might not meet current 'eligibility criteria'.

Service users were helped by such a combination of practical and emotional support. Social workers were gratified if they gained the trust of a service user, who was hard to engage, and were able to implement a life changing plan. For example, Dominic had been working with an isolated alcoholic over the previous year

'His mother wrote after he went to spend Christmas with them that they had seen a very nice change in him; so that made me feel very good' (Int 2D).

Hazel was pleased with this outcome

'I had a man who was very aggressive with a head injury. He was difficult to engage with because he disliked social workers. I had to work through this and it was very rewarding. I got him a place in a home where he has managed to settle and that gave me quite a lift (Int 17D).

Space to think

As resources were focussed on new work, support was available for immediate problems and dilemmas. As illustrated in the description of sitting in on duty, there was good hierarchical support while on the job. During my visits I often saw social workers consulting a manager in the corridor or by their desks. Andy, Sonia and Leroy were always helpful, encouraging staff to think of wider options, and advising on approaches. I noticed that managers also made time to meet staff individually to discuss difficult situations, such as adult protection, fraud and complex complaints. But they were treated as planning meetings rather than supervision.

The two senior social workers, Tony and Hazel, were also a source of knowledge and help to those who sat near. But without an allocation meeting, no-one knew which cases each other had. There was less interaction between people about their work – as opposed to social 'pass-timing'. For instance, two social workers told me how shocked they were to find that they held most of the team's POVA (Protection of Vulnerable Adults) cases. The maternity absences and long-term sicknesses impacted adversely on the team. Andy was proud of the monthly 'Teatime Talks' that Hazel had set up. But these could not compensate for the lack of space to think about the work. There was

no time made available for allocation meetings, group case discussion meetings, or even space in the team meetings for social workers to talk.

In contrast to the availability of immediate informal help, the formal supervision system appeared to have fallen away in recent months. Sessions were said to take place fortnightly for newly qualified staff and every six weeks for experienced workers, but these were not visible, probably due to the holiday period and the acute staff shortage. While I was there, Sonia, for example had her first supervision since Annie left five months before while Leroy had no immediate sessions with his staff arranged in his diary.

One reason for the lack of supervision may be that it had been emptied of any emotional meaning, in the same way as much of the care management work. It had become an over-formal and minuted meeting that focused on rational facts and statistics – needed for performance indicators and case records to protect the individual and organisation as well as government against anything going wrong. Perhaps the result was that social workers and managers felt more comfortable seeking and providing support in a more informal environment. But it would appear that the regular provision of supervision, and thus reflective space, had ceased to be the norm in these types of social work teams in 2005/6.

The mental space appears to have been lost - and with it the third position which is needed to contain projected feelings. This denied workers at all levels of the opportunity to reflect on and understand the experience. If managers had had this space they might have been able to surmount the dislocation in the team caused by the absence of the operations manager. By chance the research interviews provided some functioning space which had a subsequent positive effect on the team.

The employing authority, or perhaps society as a whole on whose opinion public funding decisions depend, appeared to underestimate the emotional meaning of the tasks given to D Team. With six employees from another department sitting in their open plan office, the team could not draw a boundary around itself. It had difficulty in defining its working environment. For example Mary, the business manager, had to calculate complex invoices in this noisy room. Nobody considered moving her into Annie's empty office. Primitive denials continued to function.

There was agreement that the duty system created and perpetuated the disruptive environment. The overall noise produced considerable stress as one worker showed

‘I have been listening to people on the telephone telling me that their cancer has advanced or their relative has died and people have been laughing really loudly next to me. Not only have I been conscious that they can hear the laughter but it has affected my ability to respond, to think through how to respond in a sensitive way’ (Note from 17D).

I was not surprised to learn that it had taken two years to move the photo-copier out of the main office. The team had no means of making and implementing decisions. This inability to manage their working environment was the obverse of the improvements which they often brought about for their service users. There seemed to be little nurturing energy left in the team. This had all been expended on their service users.

An unexpected consequence of the research

After six formal ‘observation’ visits I decided to offer interviews to all staff rather than the limited number in my proposal. This indicated that I valued them equally. All twenty took this up. This required visits to the office several times a week over a number of weeks. Meanwhile people talked to each other after their interviews, probably repeating the questions which I had asked and their responses.

Several of them had prepared carefully before our meeting. Dominic, who had been keen to make an appointment when I arrived for the duty session, was determined to have his say. Before we had finished the managers needed the room. Dominic barred the door, saying we would be five minutes. He then turned to me and said

‘You know you were asking about decision-making? Well, we are not allowed to make decisions here!’ (Int 2D).

The social work team appeared to benefit from my holding them in mind through these weeks of interviews. The team members also encouraged me to spend time with Andy by greeting me with ‘I think Andy’s in his office’, so I would drop in to say ‘hello’. Andy frequently referred to the absent operations manager and still missed her. It seemed that they had shared the management role in a successful parental partnership, but she was now no longer around to absorb her share of the projections from the team. This destabilised his management role.

I had noticed that Andy would come into the main office for social contact and support. A couple of times he sat near my desk and would sigh, as in the duty session above, or talk to engage my attention. Like me, he was not welcome in the kitchen at lunchtime. This led me to feel that we were paired together by the team, perhaps as not belonging - or perhaps I was seen as a substitute for Annie. During this phase Andy would tell me about the concerns and demands of the job: staffing, inspections, piloting government initiatives, the poor government policies, commissioning services from multiple providers - and more.

At our last meeting we talked about social work in the hospital, where I was going next, and shared views on keeping our elderly parents mobile. He reminisced how in the late 1980s the senior social workers had introduced 'reading time' one afternoon a week. He recalled that he and four others had set up a 'learning circle' where they presented cases for discussion and mutual help. Now he thought the focus was only on policy and legislation. He wondered if people knew what it was like to be working in a social services team. I said it was this concern to tell people what it was like that had spurred me to do the research. We agreed that I would return to the team in October to give them feedback on the project at a teatime talk and said 'goodbye'.

In this second part of the research project I was holding team members in mind, particularly the manager who was receiving little support from his manager. That process seemed to help him remember his earlier learning experiences from past mentors and, more pertinently, from his peer group. He was reminded of a time of creativity and potency when a small group could introduce innovative ways of managing the processes of relationship work. I left him with these nurturing memories in the forefront of his mind.

When I returned two months later, Hazel told me with pleasure that they had set up a regular case discussion group, and developed a plan to reduce noise by moving the Duty system out of the main office.

Conclusions

This team's task was to 'counteract disintegrating forces'(Winnicott 1965 p 227) - as their service users disintegrated in body or mind before them. This left an emotional legacy – a fear that they would drown in the work, as with a sudden heart attack, and the introjected impotence from their disabled service users. These characteristics had a major impact on their ability to operate in a time of adversity. The organisational culture, which did not encourage initiative, left the social workers unempowered to innovate or to make simple decisions on the organisation of their work.

Their service users needed 'keeping in mind', but the social workers needed help to do this. Local and national politicians rarely consider the number of service users with difficult and demanding personalities or considerable frailties prone to exploitation when allocating resources. The employing authority and wider community did not take account of the emotional impact of the task on the social workers. No additional space was made to help staff to work with them. Even the regular provision of supervision appeared to have been lost over the summer – and with it the mental space to allow a 'third position' to contain projected feelings. The social workers needed to keep each other in mind. But, unless they were close neighbours, they did not know about each other's case loads. The creativity needed to bring about change was held back by fear of diverting from the immediate task, a lack of structured mental space and perhaps by envy of the creativity of the three staff having babies.

The team seemed to welcome the researcher as a symbol of potential change. Though none knew how they would use me, they recognised that they were in difficulty. Once I decided to interview all the staff - to which they agreed, trust was established and communications were freed up. The manager made direct use of the mental space of our talks to connect with his internal good objects. Others found their professional voice in the interview, which they then used with others. For example, they took action to reduce the noise in the overcrowded office. They also set up protected time for a case discussion group. Only when a group has self respect and sense of self-worth does it seem able to argue for the necessary resources, rather like the infant can express curiosity best when rested and confident.

Chapter 5

The Hospital Team (H Team)

Introduction

This chapter analyses my experience in the Hospital Team (H Team), including the structural and policy background. The prologue describes the start of my research time with the team. I look at some of the roles and tasks in which the social workers were engaged, through sitting in on multi-disciplinary team meetings and in the office.

I identify the emotional content of the work – desolation and despair in the face of death – and the social work task of holding things together for people whose lives are falling apart. I consider the particular issues in work with adults vulnerable through mental or physical dependency. I examine the last week of my placement. Finally I reflect on the interaction of different life events that contributed to the particular quality of the experience there.

Background

The Hospital Team volunteered for the research project at the same management meeting as the District Team. Terry, the operations manager, thought that I would find it interesting to see the ‘unrelenting conflict over discharges and the medical view of people’s lives’ with which the team had to work. For example, staff had to contain help for someone to accept the approaching death of their spouse and the need for hospice care, while juggling with three other sensitive placement issues. Given my background, his colleague thought that I would be interested to see organisational conflicts in operation. Terry thought the research could make social workers feel valued as the primary subject. Currently they were providing information for a national project on home care which was proving onerous. This was an opportunity to observe ‘thinking on the front line’ in a very different environment.

The social work team was based in six small rooms above a day nursery. This was in the grounds of a busy 400 bedded district general hospital, which was being rebuilt around them. The hospital’s primary task of curing the sick was constrained by the

difficulty of operating within its budget. The hospital had closed sixty beds, and was attempting to meet demand through faster throughput. This presented a challenge as the catchment area had widened in recent years due to the re-siting of two neighbouring hospitals.

Since January 2004 councils have been fined through the Community Care (Delayed Discharges) Act 2003 (Great Britain 2003) for each day a patient remains in hospital due to the lack of availability of social care. The team's task was to expedite discharges for those who needed either support services at home or a permanent placement in a residential or nursing home. Councils had been given substantial grants to invest in services to ease delays. The social work team had made use of this, and recruited specialist staff: an operations manager, a finance officer, a housing resettlement officer and a discharge officer for the 'out-of-borough' cases.

The hospital managers held daily 'bed meetings' to keep a constant watch on the progress around the hospital. They continually pressed for local authority funded resources. For example, they wanted to use the social work team's 'step-down' beds, funded to hold people who were waiting for a place in a residential home, instead for patients with plaster casts taking up acute bed space. They wanted the local authority to pay for a new social work post for the short stay ward to make sure that people moved out into the community rather than into longer term beds.

Each ward held weekly Multi-disciplinary Team meetings (MDT meetings) which were portrayed as an effective way of planning patient progress. A number of different professionals were able to provide information and discuss the best way forward for each patient. Each social worker covered one or two wards according to size and likely demand for care management assessments.

The service manager, Mary, was in overall charge of the team and reported to the principal officer, at the Town Hall. The operations manager, Terry, managed the discharge process. There were two team leaders (Muriel and Liz - a locum) to manage and supervise four or five social work staff each. The two senior social workers, who had obtained their PQ 1 award, supervised one member of staff each. In total there were about twenty people in the section including a number of administrative staff

provided by the hospital. The latter confined their work to filing and preparing papers for the twice-weekly panel meetings.

Prologue

The team had agreed enthusiastically to my research. Mary had warned

‘I always say to new applicants “Forget about hand holding – it’s a conveyor belt here”. We are always under pressure from hospital targets so I have recruited two locums to take up the flack (sic)’ (visit 1H).

I thought her Freudian slip between ‘slack’ and ‘flack’ exposed her feelings of vulnerability, and the sense of being in a war zone under fire.

During visits in September, I found a lively team, who used their team meeting to debate and discuss a number of practical and case related issues – in contrast to D Team. They had received the council’s award as ‘team of the year’ with a photograph in the newsletter of the social services department. But I realised that my position in one of the six small offices would not provide a realistic view of the work. I needed to attend the MDT meetings on the wards, but did not feel confident to do this without the required NHS ethics approval. Consequently there was a two and a half month gap in my contact while the COREC (Central Office for Research Ethics Committees) system ran its course.

I returned in early January to what seemed a completely different place. Several members of staff had been replaced and three others were still away on leave. Most significantly, Mary, the service manager, had gone on long term sick leave eight weeks before, having been diagnosed with a serious though not life-threatening condition. She had come into the office that day but still felt ill. I remembered that I had asked in September what were her major concerns ‘Staff sickness and staff retention - we are all so stressed and tired, I don’t know how much more we can cope with’ (Visit 1H). She advised me to talk to Terry and the team leaders. They suggested I approached staff direct to ask to attend their MDT meetings.

The people in H Team:

- Mary – service manager
- Terry – operations manager
- Muriel and Liz (locum) – team leaders
- Kelly and Y – senior social workers
- Linda, Gail, Mike, Sam and six other social workers
- Discharge officer, housing resettlement officer
- Nick – temporary administrative assistant + three others

I made fourteen visits which included a team meeting, a hospital 'bed meeting', a period in the office, a Continuing Care Panel, and three MDT meetings. Three visits were in September 2005, and the rest in January and February 2006. I interviewed six members of staff: a social worker, the discharge officer, a senior social worker, the service manager, the principal officer and the operations manager.

Sitting in on an MDT Meeting - Part 1

1. Linda was on the telephone when I arrived, but gathered her papers and we walked over to the ward together. She told me she had been in the borough for eight years. After a start in Children and Families, she moved to the Community Adults Team and then to the hospital at the time of the restructuring three years ago. She preferred this to the long term work in the community. Linda mentioned the difficulty of discharging people when they still felt anxious and unwell. But there was no discretion under the new discharge policies.
2. On the ward we walked down the middle with about nine beds on either side. We passed a variety of patients – an obese youngish man, a wizened old man and some in between. Several members of staff said 'hello' to Linda. She explained that she had also been an inpatient here and remarked what a surprise that had been.
3. Linda introduced me to the senior nurse, called Ella. They commented on the lack of staff around that week. They shared plans for their imminent holidays to the same island in the West Indies. After a short while we took two chairs and squeezed into Ella's minute office. I asked if I could record the meeting and they agreed. I also took notes but even with those it was difficult to follow the summaries of the patients' situations.
4. N: 'Okay, we have a guy in Bed 1. He's Mr D - he's 36 years old. He's been vomiting blood. He is Somalian. We're trying to get his niece to interpret.

Next is John R. He is 47 years old and has a compromised immune system. So we are barrier nursing. He is for 'resusc'.

Then there is Janet V. We don't need any social input. She lives with her son. She can do her own cooking and cleaning'.

5. N: 'In bed 4 is Mr C, he is 42 years old. He has pneumonia with respiratory failure and sleep apnoea. He is the guy you saw on the right.

SW: Is there anything you can do with his sleep problem? Is it a consequence of his obesity?

N: It's also because he has COPD (Chronic Obstructive Pulmonary Disease) as well. His sister came in and helped to wash him. Since then he has been doing it himself. He has been managing'.

SW: 'Do you know how he manages with things like cooking, shopping, laundry and house work?'

N: 'No. I think his sister is doing that for him'.

SW: 'So there will be no social input'.

6. N: 'In bed 5 is Mr M. He is deaf. He is 81 years old. He has an infection and epilepsy. He has dementia, hypertension and Alzheimer's. He is very restless. He physically abused the staff and was kicking at them. He probably had some type of services in place given his age'.

SW: 'But it depends on how he was coping before. If he was able to do things himself he might not have been offered a service. Is he mobile?'

N: 'Not really. He tried to get out of bed last night and he fell. No relatives came with him. None have come to see him since he's been here'.

SW: 'Are they talking about a placement for him?'

N: 'He lives nearby'.

7. N: 'This next person has an ulcer and pyrexia. He has a bypass and chronic anaemia. He is an amputee. His amputation is on the right. He is not diabetic. He has been to a panel. And he is going to residential anyway. He is basically sorted out.

The next person is Mr F. ..

Then there's Mr B ...

8. N: 'In Bed 9 is Mr A. He came in with chest pains- a pulmonary oedema. He has had hypertension and raised cholesterol in the past. They are keeping him in because his relatives are due to come in and sign a form but they have not been here since he arrived. The doctor said that he would be transferred to a step-down bed.

SW: 'That doesn't make sense to me. Who is his social worker? Is he talking about me or does he have another one? I don't really know anything about Mr A. Somebody might be working with him. It looks as if he has a district social worker'.

N: Yes, the district social worker has been in touch.

9. N: 'By the way Mr E. is back and he's on the other ward'.

SW: 'What are they doing there that he could not get done at home?'

N: 'He went home one day and then he came back'.

SW: 'What was that about?'

N: 'His relatives got him home. Then the district nurse did not get there at 5pm. They started to panic. They verbally abused us. They verbally abused the

Indian nurse. They said that they were bringing him back down. After they had verbally abused us, the district nurse showed up. They sent her away. They brought him here and we put him in a ward overnight. He did not really need to be readmitted. But that is the family for you'.

10.N: 'This next man is MRSA positive. He has dressing to the wound in his right leg. He's 92. They have panel agreement for a nursing home. Can you give me a date him to go?'

SW: 'No, I know about him but I didn't deal with him. But I can find out for you. I will let you know. I think Gail might know'.

A reflective commentary - Part 1.

Linda's early comment on the lack of discretion surrounding patients' discharges (1) put the social work team's primary concern at the forefront of my mind. The arrangement of discharges sounded a challenge in the face of someone's anxiety or continued feelings of ill health and vulnerability. What defences did hospital staff need to develop to carry this out? The central conundrum surrounding the funding of 'Continuing Care' was to decide where curing stopped and caring started. The legislation appeared to represent the fault line between the two services.

This was my first visit to a ward during the project. I lacked the familiarity that I had earlier with the District Team's office and service user group. I felt embarrassed walking down the centre of the ward (2). I was struck by the arrangement of the beds which exposed all the patients to passers-by with no privacy.

Linda seemed to have an easy working relationship with the other staff (2) and the senior nurse Ella (3) which I found reassuring. They appeared to have worked together for some time. They knew what to expect from each other's roles. This was helped by the additional connection of sharing a country of origin (3) and the fact that Linda had been admitted to the ward in the past.

The important role that relatives played emerged early in the meeting. Staff appeared to rely on them to put their patients into context: for example, the Somali niece to interpret (4), Janet lived with her son (4), a sister helped her overweight brother (5). However the confused and unhappy Mr M (6) appeared to have no relatives to visit him, while Mr A (8) could not move until his elusive relatives appeared.

I felt sorry for Mr M who was mentioned rather brusquely (6). Was this due to his behaviour or to his lack of family, and therefore the absence of any sense of the person behind the illness? I wondered if his aggressive behaviour was due to the infection, as I knew was sometimes the case. I also wondered if the staff had had any training in working with people with dementia. I felt sympathy with anyone who wanted to kick against a total institution.

Mr E (9) illustrated the extent of the fear and distaste that a particular illness or disability can evoke in carers. Menzies (1970) considered the role of relatives in her hospital study. She thought that they could be

‘demanding and critical, the more so because they resent feeling that hospitalization implies inadequacies in themselves. They envy nurses their skill and jealously resent the nurse’s intimate contact with ‘their’ patient.’ (p7).

She also noted that sometimes the stress on the family of caring for someone ill at home was severe enough to allow for the patient’s admission to hospital (p8). It transpired that this patient had to be fed through a ‘peg’ in his stomach, and the district nurse had visited to show the family how to do this. Unlike the hospital staff, family members were clearly ill at ease with this procedure (9). I was struck by the senior nurse’s matter of fact acceptance of their anger against the hospital. But this also meant that she did not think of addressing the fear that lay behind.

I was prompted to think about the way the hospital with its hierarchy seemed to provoke dependent and regressive behaviour from families, visitors and from some staff members. I wondered if there was a place for a more sensitive discharge procedure, perhaps involving a volunteer, who could help patients and their families ‘over the threshold’. I was not sure that staff in the hospital appreciated how strange and alien home could often feel to patients on discharge, or how frightened families could feel to be responsible for their relative’s care. Social workers thought a great deal about transitions and would be well placed to contribute to hospital policy.

Sitting in on an MDT meeting - Part 2

- 11.N: ‘You heard about this next man who came in not eating or drinking. He has a history of a number of things including TB. He came from a nursing home. The nursing home basically wants him transferred somewhere else. He’s not for ‘resusc’.

SW: 'That home is usually pretty good -- what is the matter?'

N: 'I don't know. They say that he has behavioural problems. He is fine in hospital but is a problem for the nursing home. He is quite antisocial. He pees into cups. He also does other pretty horrible things. So they want him to have an EMI (Elderly Mentally Infirm) assessment.'

SW: 'We need some further investigation there. Gail might know'.

12. I lost concentration here as I had just noticed on the pin board opposite me several 'Celebration of the life of...' pinned up. I was not sure what they were. One had a photograph of an attractive young woman on it and a date (1970-2005), and the other photograph was of a teenage boy. I realised they must have been Cystic Fibrosis patients. Linda had told me that four beds were reserved on the ward for them but they did not form part of her caseload. I was shocked to be reminded that such young people die.

13. N: There is another case...

N: Then there is Phoebe -- but that is probably finished'.

SW: 'I spoke to Phoebe's son yesterday. He rang up and wanted to speak to somebody. He wanted me to explain to him how the assessment works. He wanted to know the procedure. I explained and he was quite happy. I will ring him up as I would like him to be there when I do the assessment'.

N: 'He will be very happy'.

SW: 'Hopefully he can come in tomorrow or Friday, or possibly Monday'.

14. N: 'There's another lady who came up for an MRI. She has had fits. The first one was due to dementia and the second to a chest infection. She was screened when she first came in. But she has dementia. She has arthritis in her neck. Her husband said that at home she sits in the chair and her neck has been going down. It has been arching forward. I don't think her husband is going to be able cope when she goes home as she can't do anything'.

SW: 'I haven't seen this. I had better take this'.

15. We were joined by another nurse who had come in to use the fax.

N: 'I am sorry about these interruptions. It is a good thing that these fax machines work. Oh dear no, it's not working. We should be moving into the new buildings hopefully at the end of this year, instead of this dilapidated old thing'.

June: 'I have sent section 5s on this to Barry.

16. N: 'The next lady is 54 ...

N: 'The next lady is 85 years old. She came here for rehab. She lives locally. She had a huge package care but she would not let anyone in. She likes to lock herself in and tell everyone to go away.

And then there is Martin. He's 35. He is a CF (cystic fibrosis) patient. He needs no social input.

And Bed 18 is Steven. He's another CF patient. He's 19.'

17. The meeting ended and I thanked Ella and assured her that I would ask Linda about any queries. We walked back to the office together. Linda explained that her first task was to contact the relatives so that she could put the assessments forward to the Monday panel. As it was already Wednesday, she needed to see them in the next two days to complete the paperwork in time.

18. She described how challenging it could be to speak to relatives 'It's very difficult to talk because sometimes they have mobiles or answer-phones. I had a bad experience last year. I rang someone and left a message. And the person rang me back and I had left a message on somebody else's answer-phone. It was a difficult message to a difficult person. He was upset because his mother was in hospital. So now I don't leave messages. I wait till I actually get people'.
19. I asked about the Banding system which Linda described to me 'Basically we have to get agreement for Band 1 cases which are paid for by the hospital under 'Continuing Care'. They have panels to approve cases twice a week: Monday afternoon and Thursday morning. We don't like the Thursday morning meeting because it is held very early and the papers have to be done on Wednesday. So that is a very tight turn around. The doctors don't realise that.'
20. 'Doctors will say to a patient "Well you can go home" when they need services. It gets really tricky. The patient says "Well the doctor says I can go home"' Then they go home without any services. When they get home they realise that they can't cope. They ring the district office. And the district office says "Why didn't you do it when she was there?" We had one this morning. This lady wanted to know why her services hadn't been set up when she was in hospital. I said "I didn't even know this lady".
21. I asked Linda about the decision making on resuscitation and non- resuscitation. She told me that she had been involved with families who had made that decision. She realised what a difficult decision it must be to make, especially on behalf of someone else.
22. She talked about different posts she had held in the borough and mentioned that 'Just before I came back to work from that period off sick, I found out that I was a diabetic. I have found it really frightening seeing the effects of diabetes on people in the community. I have made sure I have been able to contain it.' We arranged to meet the following week for an interview. I thanked her for taking me along to the meeting and said good -bye.
23. I looked in at the other offices and saw that Terry had gone to the daily 'bed meeting' and Sam to his MDT meeting. The reviewing officer and housing resettlement officer appeared to be the only members of staff present. Nick the temporary administrator told me that Mary, the service manager, had withdrawn from work after all to continue her long term sick leave, when I had just seen her the previous week.

A reflective commentary - Part 2.

The nursing home's concern to have their difficult resident (11) placed elsewhere, along with Mr M in (6), highlighted the considerable challenge facing society to look after people with reducing physical and mental powers. Even those with devoted carers

such as the disabled wife (14) were in an unstable situation, as their partners aged and waned alongside them.

The comment made in passing that a patient was 'not for resuscitation' (11) sent a chill through me. Though in intellectual agreement with the need to make and to implement difficult decisions, it jarred emotionally against my internalized image of a hospital as a place of healing and care.

I was shocked to absorb the full meaning of the commemorative sheets pinned on the notice board (12). These were stark reminders that death came to young people as well, and they intruded on my thoughts and on the meeting. Nothing in my previous three visits to the office had prepared me for this. I may have particularly noticed them as my nephew had died from cystic fibrosis many years ago. I wondered if their families had any help towards the end.

There was a sense that Phoebe's (13) assessment and placement was a joint enterprise with her son. This seemed to allow both Ella and Linda to respond with warmth to both. The elderly couple in (14) illustrated the way that a hospital admission could shine a spotlight on someone's condition and precipitate a change in care or accommodation. This traumatic shift was common. Smith (2007) referred to about one third of all residential admissions being from hospital.

The whole hospital information system was based on faxes between wards and departments (15), but it was unreliable. The use of discharge time limits (as with Section 5 which gave the Social Services under three days to find adequate alternative care for the patient) made essential the requirement for rapid and secure means of sharing information. Ella equated the broken down fax machine with the dilapidated state of the hospital. This reminded me of the additional strain always felt when builders were present. It must have been a considerable challenge for managers and staff to persevere under their current conditions.

The elderly lady (16) who refused everyone entry to her home represented another challenging service user group in the community. In retrospect I am surprised that I did not ask Linda if the cystic fibrosis patients (16) received any social work support after Ella's comment 'He needs no social input'. Perhaps I wanted to avoid learning that

they were no-one's responsibility. That would have been too close to my own experience.

The timescales to arrange discharges (17) created much pressure. Something as straightforward as contacting next of kin became fraught with the complexity of modern communication systems (18). Yet the timescales were only feasible because of email, mobiles and faxes (19). After my time in the District Team, it was interesting to hear the problems of arranging services (20) from the other side. Being disturbed at the life and death choices, I had to ask about resuscitation (21). I was relieved to learn that families had access to a rigorous procedure.

When Linda told me of her diabetes and mentioned how frightening she found the effects of diabetes on people in the community (22), I wondered if she felt instinctively more protected within the hospital institution given its offer of 'cure'. By transferring to a hospital post, she may have found the psychological support which she needed to continue to work in this area.

My strategy of going to MDT meetings was confirmed to be productive when I found the offices nearly empty on my return (23). The initial discussion and any thinking about cases seemed to take place within the hospital wards. Staff recorded information in their offices and used their colleagues for advice on arranging services. I was concerned to learn from Nick that Mary had gone off again on sick leave (23). I thought how difficult it must be for the team to have this uncertainty continue into a third month, in addition to the extra management load. I slept on the train home, worn out by the emotional experience of the afternoon.

Desolation and despair

'There was one old lady like a little sparrow who had pushed her chair out so as to catch people as they walked by the end of her bed, repeating "Are you the Doctor? I want to go home" in the most distressing way. Her cotton robe was hanging open at the chest and I felt very confused as to whether to stop and straighten it for her. But what would I do when she clung to me? And would that make it worse? I walked on to the meeting room, disturbed by the scene and my feelings' (Visit 5H).

On the following day I returned with Gail to a ward with twenty eight beds for older people who had suffered strokes. I was assailed by the sense of desolation and despair. The meeting did nothing to alleviate this since only the consultant and the ward doctor spoke. The other nine participants sat silently for two hours. There was no attempt to develop a rapport between staff or to use the meeting to explore problems and dilemmas. The oppressive attitude of the consultant seemed to mirror the repression of any life and individuality in the patients. Perhaps signs of life would lead to more despair by patients, which staff were not equipped to tolerate. Perhaps the staff's confusion on the best way forward would be the same as mine? I spent the time preoccupied, worried that my father-in-law was in a similar ward. My notes were as monosyllabic and lifeless as the meeting

A personal interlude

My personal situation was entwined with the placement and influenced my perceptions of it. My elderly parents-in-law were reaching the end of their long lives. They lived in their own home with some daily help for my father-in-law. When he could no longer climb the stairs, he was admitted to the local hospital for assessment. After the second MDT meeting referred to above, I visited him the next day. We had a remarkable talk. This consoled us when he died suddenly the following morning.

I stopped my placement for two weeks for the funeral and returned for the month of February, conscious of another break in relation to the team. In my last week, my mother-in-law was living alone for the first time in her life, with the prospect of all her children being out of contact for the following week. We were all preoccupied and anxious as to how we could help her 'hold it together.'

The last week of the placement

Monday

I had arranged to attend the continuing care panel chaired by Dawn, the principal officer, on Monday afternoon. She arrived early and took the opportunity to describe her current work situation to me. The reorganization was clearly taking its toll on the senior management team as the trade union had advised staff not to co-operate. She

had no administrative support and had to cover for two colleagues while they attended an Industrial Tribunal.

On top of these demands, a legal judgment had just been delivered on the 'Grogan Case' (Grogan v Bexley 2006), which would affect all decisions on the funding of continuing care placements. Its implications for the department were not known, nor for the meeting which we were about to attend. Dawn had drafted a paper for the senior management team and was seeking views of colleagues. She complained several times of a 'crisis of capacity' in the organization. She explained that the time of the policy officer was dedicated to managing the Department of Health's performance assessment framework. I wondered if it was a 'crisis of capacity' for the senior management team. In apparent answer to my thoughts she suddenly remarked 'I think more desk work is needed. They say we ought to get out but I think social workers should do more at their desks'. Perhaps this sudden wish to make people sit at desks implied that they would then think hard. Was it a cry for more mental space for the organisation and the people working in it to think, reflect and digest such issues as the Grogan judgment?

At the continuing care panel I was struck by the sensitivity with which heard and commented on the cases at the meeting. This appeared in marked contrast to the way patients were discussed on the wards. As the budget holder for the Primary Care Trust was not present to challenge their decisions, the others may have been enjoying a break from the usual pressure and conflict.

Tuesday

The following day I found that my appointment with Sam had been double-booked. This upset me and I worried if I could continue to hold the research project together. So I was relieved to be able to sit next to Mike for half an hour.

Mike continued to slowly copy-type an assessment form, which he had completed by hand on the ward. The telephone rang. Mike answered it, telling the caller that 'All these discharges are doing my head in'. He complained to the caller that the ward wanted to discharge a patient when they knew nothing about the home situation and before an occupational therapy assessment. Also her physiotherapy treatment was still unfinished. Mike began trying with one hand to look up someone's name for the caller

on the computer system, awkwardly holding the phone in the other. He told the caller he would ask the administrative worker and left the room for several minutes, eventually telling the caller that the patient was not in the borough.

Mike started back on the copy-typing saying there was a negative side to all this fuss about beds. He had been at a meeting when the consultant was too clinical. He had said that a woman coming in for a knee replacement must be told that she had three days to recover and then go home. Mike had said to the consultant 'How about treating people like human beings? They are not machines. People react differently!' He laughed, commenting that they never invited him back to that meeting.

Mike described a difficult situation on the surgical ward. A man came in to have his arm amputated above the elbow – he had not visited the doctor and it had gone gangrenous. After the operation the fingers on his right hand were discolouring. He refused services and was totally unrealistic. When Mike explained the danger of further infection, he became unpleasant and abusive. I began to feel overwhelmed by the nauseous detail. Mike relentlessly described a second case where the patient had a leg amputated. He explained that the doctors put pressure to discharge such patients through the threat of Section 5 notices, rather than discussing jointly the best way to handle them. I was relieved when we were interrupted and I could say 'goodbye'.

During this brief visit I saw Mike create for a telephone caller the same frustrations that he had on the ward. His conversation demonstrated his determination to make ethical discharges, and not to collude with the ward staff in sending someone home too early. He projected into me the same details of gangrenous limbs and disintegrating flesh that the patients had projected into him. It linked in my mind to my third MDT meeting the previous week. There, two members of staff had been discussing a young man with a bunion removed who now had a sudden rise in temperature. I subsequently realised with alarm that they were anxious he might have septicaemia which, if ignored, could lead to amputation.

As I left the office I had an unpleasant sense of vertigo, as if I was on the edge of a cliff or volcano and everything was falling away around me. Was it due to the cancelled interview? Or too much pressure and rush? Or was it my mother-in-law's situation? I

did not know. I wanted to distance myself from the hospital and all that it stood for. I was relieved that I had only one more day.

Speck (1994) refers to times when over-identification with a client and their situation can strain one's professional boundaries and sense of reality. At that moment I was probably over-identified with the team and equated its task of holding everything together with my family's task.

Wednesday

As I made my way to the hospital the next day, the train station was in chaos after an accident down the line. I was relieved to find Terry in the office. He had told me the week before that he had handed in his notice and was leaving in six weeks. He had given them some extra warning in time for the restructuring. His interview put a spotlight on the discharge process, on motivating managers, and on the pressure organizational change puts on a staff group.

He explained that the hospital's closure of sixty beds to balance its books had raised the number of referrals to the social work team. This had increased the pressure on him to manage the delayed discharges scheme without incurring penalties. As he said

‘I have had to become slicker in managing where the pressures are. I keep lots of spreadsheets: where we are with the referrals, who is ready for discharge etc. I am constantly chasing social workers. I am terribly well organised. I have all the details on referrals at my fingertips. It's the only way I can manage an unmanageable situation’ (Int 3H).

Terry's description of the way the system was ‘developing into a much bigger thing’ gave me a barely perceptible tremor of alarm. I realised that systems devoted to the movement of vulnerable people can easily add to the reification of the patients concerned. Unless coupled with expressions of individuality and humanity, they may carry overtones of a ‘final solution’. Dartington (1994) describes

‘how ‘hospitals are bursting with intense primitive anxieties about the potential sadistic abuse of the power staff have over patients. Everybody has these dreadful thoughts but nobody ever speaks about them’ (p103).

Reading this, I was relieved that someone else had also recognized this potential for abuse.

Terry's ability to create and manage a matrix of monitoring systems was impressive. But he was not commended, instead he was reprimanded for not relying on the council's computer system. The senior managers in the department appeared to prefer conformity to solutions. He described how he had tried to take unpaid leave. While other employers have become flexible in their efforts to keep good staff and devise ways to improve and maintain workforce morale, the local authority was concerned to avoid creating precedents. He had then given in his notice. I felt I was witnessing an unnecessary attrition of skills from the group.

Terry described the impact of the restructuring process on the managers in the team. He had just told the staff that the team leader, Muriel, had not been reappointed but would be found another job. He explained that he and Liz could not supervise all the social workers

'So we said until new managers come, we will have an open door policy and offer informal supervision with anyone who needs it. If they have a case that needs discussing or any issues where they need to sit down with a manager, we will have an open door policy and deal with them ad hoc. It is not ideal but it is the best that we can do' (Int 3H).

When Terry explained Muriel's situation and the uncertainty over her absence in the last two weeks, I realised what had been happening. My sense of vertigo the previous evening had been an accurate counter-transference experience. The team's management really was falling apart.

Terry was desperate for some help and guidance for the team, using the word twice in one sentence. I wondered if he felt that they were poorly supported by the senior management. For instance, Dawn, heavily preoccupied as I had learnt, had not volunteered to talk to the staff, instead Terry had to ask her. He may also have felt that he and Mary had not received adequate support and understanding, which had contributed to Mary's sick leave and his departure.

It seemed that he, Mary and Muriel were being discarded like worn out cogs in the machine. Stokes (1994) refers to the way that change

'can be driven by a manic and contemptuous attempt to triumph over difficulty and conflicts. Feelings of compassion are cut off and the capacity for concern is projected on to others who are then seen as weak' (p 127).

This may have happened to Mary. Terry was leaving before it could happen to him.

I was relieved to finish the placement. When I said goodbye to Nick, someone in the team to whom I had felt able to turn – and incidentally the most junior - he told me that he was also leaving at the end of the week. This seemed fitting. Later that evening I was captivated by the quote Bion (1997) gave ‘Golden lads and girls all must, like chimney sweepers come to dust’ (Shakespeare 1609). This put into words my unfocussed anxieties. It allowed me to feel and express my sadness for my family and for the Hospital Team and their service users. The words and my expression of feeling let the over-identification fade and reality return. I could then distinguish between the two situations and recovered my ability to think.

What is the emotional meaning of the work?

The dominant emotional meaning of the work seemed to be linked to the desolation and despair stimulated by the approaching deaths of the service users. Aries (1976) in his study of attitudes towards death refers to

‘the inhumanity, the cruelty of solitary death in hospitals and in a society where death has lost the prominent place which custom had granted it over the millennia, a society where the interdiction of death paralyses and inhibits the reactions of the medical staff and family involved’ (p 102).

You cannot get higher stakes than life or death. The higher the stakes, the more intense the unconscious conspiracy needed to hide the truth.

The social workers, like the nursing staff, could not work in an atmosphere of desolation and despair. I spent two half days with the team, oblivious to the reality of their work within the hospital. They had built up strong protective defences. The emotional meaning of their work (Hutton, Bazalgette and Armstrong 1994) had been shaped by two years of intense pressure as they implemented the Community Care (Delayed Discharges) Act 2003. They no longer had the satisfaction of ‘putting cases to bed’ (Int 2H) or ‘doing a good assessment and providing a package of care’ (Int 3H). The team’s emotional experience appeared to be entirely of things falling apart.

The lives of all their service users were falling apart. People who made good recoveries did not need their services. The social work task was to hold together the physical and emotional aspects of patients while they were discharged from hospital.

The care management assessments had to pull together an appreciation of the patients' lives and living conditions from partial and fragmented snippets of information like those mentioned in the MDT meetings: eg "sister helps" or "likes Classic FM".

Roberts (1994) comments on the impact of moving into residential or nursing care for the individual.

'Crossing the boundary into such institutions means joining the category of non-contributing, non-participants in society they lose ...all opportunity to continue making decisions for themselves. Being treated differently from self-caring and able-bodied people they experience great loss' (p 79).

Service users in the hospital were faced with these difficult emotional dilemmas brought about by their increased dependence. They often had to make the major transition from their own home to some form of residential care. But the environment within the hospital, the family and society, did not take account of the emotional impact of these transitions. The social workers were the only people in the hospital structure likely to offer space to a service user to acknowledge the psychic importance of what was happening to them. I suggest that the acknowledgement of the feelings of the service user would form part of an 'ethical' discharge. I was uncertain how realistic this was when most assessments were completed over one or two meetings at the most.

I feared that the team's process of 'holding it together' for the service user had been reduced to the mechanics of assessment for a care package or submission of papers to the continuing care panel. Mary had identified their work as a conveyor belt. I saw that the workers were as much controlled by this as were the service users on it. The team had a key role in the hospital system, but it meant working with the values and priorities of the hospital. These priorities appeared to conflict with their responsibility to acknowledge the losses of the service user. Sam admitted that he 'found it hard to get a handle on their lives in this rapid moving hospital situation. It had been much easier in the community where he had felt more in control' (Visit 2H). The social workers were cut off from their colleagues in the community who only made contact to complain. They also had little to do with the other social workers who shared their premises and worked in child protection or substance misuse, and who might have reminded them of other dilemmas and situations.

Defended against feelings of desolation and despair, the emotional experience of working in the hospital social work team seemed to be of everything falling apart. Their social work task was to hold it all together. What they decided to hold together and how far they were able to do this depended on their ability to think about the task.

Space to think

By the end of my placement in the hospital I also thought the team was handling the workload in the only possible way – ‘doing’, not ‘thinking’. Dartington (1994) pointed out the negative expectation in the 1980s and 1990s that nurses should not think. She defined thinking as

‘the processes of reflection about one’s work, its efficacy and significance: registering what one observes of the patient’s emotional state, the capacity to be informed by one’s imagination and intuition, the opportunity to criticize constructively, and to influence the working environment’ (p101).

This definition encompasses how most social work professionals would also define thinking. Were the team able to carry this out at all?

Informal support

I was told in an early visit that staff received most of their support from peer supervision in their offices. Again, on our way back from an MDT meeting, another social worker emphasised ‘It’s the support of one’s colleagues that matters’ (Visit 9H). The small offices encouraged peer group sharing. I often heard staff checking out practical matters like eligibility criteria between themselves. One social worker said

‘Although it’s sometimes total madness, I feel that here we bounce ideas off each other and it is more stimulating as a group’ (Int 2H).

When I first came in September, both managers had an open door policy for consultation. The team leaders and senior social workers were also approached for information. The discharge officer, who was not from a social work background, said

‘They are fantastic managers. I can’t speak highly enough of them. If you go to them with anything they will help you. They are all very good people. They just let you get on with it’ (Int 1H).

The advantage, as I could recognise from my experience of managing a referral and assessment team, was a smooth running day-to-day system, but with little capacity for critical appraisal of the task.

Supervision

When I first visited, the supervision system was functioning normally. The departing team leader said she saw everyone once a month, and new people, such as Sam, more often. However there was quite a turnover of supervisors. Two of the social workers had four supervisors in the last year or so. One social worker told me what she expected to take place

‘At supervision we discuss most things actually. Caseload - whatever with your caseload. MDTs - if you are having any problems. Adult protection. Training. Any problems with your IT’ (Int 2B).

As Terry made clear, he and Liz had had to abandon formal supervision in the absence of Mary and Muriel. It had petered out three months earlier when Muriel was on leave and Mary first went off sick. Hence staff were receiving minimal support or space to think about their work, or the multi-disciplinary relationships that sustained it.

Training and development.

Hospital social workers were not the post qualifying (PQ) target group of the Social Services Department. They had to be highly motivated to gain access to the post qualifying framework. Kelly, for instance, had obtained her PQ1 through the department. But she was financing the second stage herself at a nearby university, using time off in lieu for short absences. She found the experience stimulating. She was doing a research project into multi-disciplinary working, which she saw as the future for the hospital.

In contrast another social worker said

‘My plan for the future is to retire. I have not got into the student supervision bit. I must admit that when I finished my training it was one of the things that I wanted to do. But since working here, though I still think it's a good thing, I really don't think that time warrants it’ (Int 2H).

Her initial aspirations had remained un-nurtured and unsupported in the hospital environment. The Social Services Training Section was still running training courses.

Sam, for instance, attended half a day on Bereavement and Loss, which he found helpful in giving him confidence to approach many of his older patients. Compared with the other two teams, hospital social workers worked in isolation from their colleagues. There were no opportunities for joint working and therefore new members of staff took time to establish effective working relationships with multi-disciplinary colleagues.

Team meetings

The team meeting I attended in September was focused, interactive and participative with plenty of debate and ideas shared. This contrasted with my experience in D Team. Not everyone supported its use for reflective thinking

‘If you have an interesting case it's something that you can discuss at a team meeting. You can throw it up and say “Has anyone got any ideas?” I think because the turnover can be quite speedy here one should put cases to bed and forget about them. And you move along to the next thing’ (Int 2H).

However one social worker did bring a case for discussion

‘A social worker asked the group rather timidly “what do we do with a patient who says she is not happy at her residential home?” Colleagues made various suggestions of people to contact. But the social worker said she was worried that it was only the tip of the iceberg. For instance, the patient was not being taken to the toilet when she wanted to go.

The operations manager said that the reviewing officer was the best person to involve. The social worker however said she thought she would suggest the patient moved homes’ (Visit 1H).

No one verbalised the fears of the social worker about abuse. Even the team leader, normally very sensitive, did not mention adult protection issues. The social worker did not respond to suggestions of help from the reviewing officer. Moving the resident, as she concluded she would, seemed to be a flight from her anxieties. It would help this client, but not the other residents of the care home. I wondered later if this was part of the team's need to avoid a constant exposure to pain and distress which was evident on each of my three ward visits.

MDT meetings

Each social worker had to establish their own professional authority with the hospital consultant and the team of staff on the ward. Two experienced social workers told me

proudly of times that they had intervened, telling the consultant that they should be inviting comment and listening to others, since this was a multi-disciplinary meeting. However, in two of the three meetings which I observed, neither the social workers nor other staff spoke. Admittedly one of the social workers explained that she needed to keep her head down as she had too much work from her other ward. But the other had been handed six cases and felt unable to protest. This questioned the purpose and effectiveness of multi-disciplinary team meetings, as well as the training and support available to the social workers. Kelly affirmed 'I'm not a person that shies away from asserting my professional role and also helping other people do the same.' (Int 4H) Social workers like Gail, however, were on their own in MDT meetings with few opportunities to learn the representational role through observation of more experienced workers.

What motivated the social workers?

The social workers liked the intense experience, the throughput of work, and the sense that they would quickly become 'expert'. They were a successful team and had delivered the required discharges against considerable odds. But it was at a substantial cost to the managers' well-being.

Menzies (1970) explains that we often use objective situations in our work to try and master our disturbing internalised phantasy situations. When we are able to manage the objective situation, we can allow this to be a symbol of the phantasy situation. We can then be reassured that we are also mastering our internalized worries as well. Thus social workers may gain satisfaction from their expertise in 'holding it together' as they move vulnerable people from hospital to the community. This may help them to master internalised destructive forces such as 'letting it fall apart'.

But Menzies points out that when the symbolic objective situation equates with rather than represents the phantasy situation 'all the anxieties aroused by the phantasy object are aroused in full intensity by the symbolic object' (p8). In the last week of my placement, the management of the team was actually falling apart. This 'symbolic' situation aroused the full intensity of the team's unconscious anxieties, which they projected into me across my weakened unconscious boundaries. These boundaries had been weakened by the simultaneous co-incidence of my family life falling apart.

Conclusions

At the time of my visit the Hospital Team had been working on their 'conveyor belt' at full stretch for two years. It provided empty beds for the hospital by arranging care services or residential accommodation. It continued to attempt to make ethical discharges in the face of constant pressure from the hospital. However the Team did not appear to have adequate support to provide service users with the emotional containment needed to manage successfully the demanding transitions and losses involved.

Through their role on the boundary of the hospital, the Hospital Team seemed to have been recruited to contain all the fearful aspects of suffering and death on its behalf. Having been rendered professionally powerless by the legislation on delayed discharges, they had to accept their part on the 'conveyor belt'. They appeared to jettison the space to think critically about their work along with their responsibility to make independent decisions.

The team's management fell apart. The managers had absorbed the stresses and conflicts across the margins of two institutions and were now worn out, like parts of an overstretched machine. One had become ill; the other resigned and left the profession; a third had never been replaced; and the qualities the fourth manager possessed were no longer considered suitable for the job. The management team collapsed over four months along with the effective support and guidance they provided to staff. Without a manager, the team had no spokesperson to tackle their opposite number about the malfunctioning administration. Unchallenged, the MDT meetings would continue to take the time of social workers without improving interprofessional understanding or communication.

Why had this happened? It appeared that due to emphasis on throughput, the team had lost its ability to find a third position needed to examine critically its work. Away-days to look at their role in the hospital and community were not utilised – nor were case discussion sessions, subject based study sessions, or supervision. Perhaps the emotional well being of the managers had been forgotten by the Senior Management Team in the throes of their restructuring project (Stokes 1994), just as the managers

had been asked to ignore the emotional well-being of the service users in the interests of efficiency.

The depersonalisation of patients may have led to the depersonalisation of the whole team. In 'holding it all together' the organization did not acknowledge the emotional content of the task for the service users or for the social workers themselves. Were they perhaps influenced by an outdated 'medical model' that denied the emotional context of illness? Would this have made a difference? Without some creative space to rethink the task and to renegotiate a more equal relationship with the hospital, what will prevent the next intake of managers from burn-out and disillusion?

Chapter 6

The Mental Health Team (M Team)

Introduction

This chapter covers the work of the Mental Health Team (M Team). It describes the start of my relationship with the team, then examines the roles and tasks that the team undertook, and the structures which they had put in place to do this effectively.

I reflect on my counter-transference experience to explore under the surface of their professionalism, and to discover the emotional meaning of the work which drove their behaviour. This appeared to be fear of exclusion or being ostracised by the group. I examine the impact of this emotion on the team's functioning through the observation and interviews, and through analysis of the group's concern about a client.

Prologue

I gave my introductory letter (Appendix 2) to two dozen social work mental health managers at their liaison meeting. One asked for an email version. One of her five Community Mental Health Teams (CMHTs) responded. Dave, the job-share manager, invited me to meet the team in May 2005. He was my link from the start. I was given a professional grilling by the dozen team members. None said to which discipline they belonged.

I was pleased but surprised to pass the test. Their only stipulation was that I should not observe supervision sessions. I was happy to comply, having discovered D Team's reluctance to be observed in supervision. We agreed that I would contact them again when I had received NHS ethics approval and knew my potential start date. They were still interested when I approached them in March 2006. I met Dave to learn about the team and its work.

Dave explained that the team was not strictly a CMHT. It had been established in the 1980s to provide specialist mental health services for homeless mentally ill people in

order to reduce the number sleeping on the streets. One succinctly described their client group as those who are 'rough sleeping, borderline and psychotic' (Visit 9M). The overt primary task of the team was to attend to the mental and social wellbeing of this elusive group, who had excluded themselves from society, but continued to create considerable anxiety there. Their parallel task was to protect society from the potential danger which these service users were perceived to pose. These twin objectives sometimes led to a conflict for staff.

The team occupied the upper floors of an old property, with a large office for the majority of staff and two other rooms. It was on a busy road by a large railway station, in an area noted for its transient population. The secure entry was shared with a walk-in health clinic for homeless people on the ground floor.

The team worked closely with an array of agencies which focussed on the needs of homeless people across two boroughs. It had about 130 clients on the books. Most referrals came from the Street Services teams and others from neighbouring CMHTs. All the clinical staff regularly covered 'outreach' sessions in the early morning and late evening to follow up referred people, sheltering for the night. They also linked with an acute hospital ward, day services and a number of hostels. Aided by the information officer, they had considerable knowledge of a wide range of available resources for rough sleepers.

The people in M Team:

- Dave (Approved Social Worker - ASW) and Sally (Community Psychiatric Nurse - CPN) job share managers
- Ed – psychiatrist full time; SHO (Senior House Officer) psychiatrist 2 sessions
- Consultant Psychiatrist – two sessions (timed for their meetings)
- Wendy and Peter (CPNs full time) Lynne, Jane, Carol, and Tess (CPNs part time)
- Julia - occupational therapist full time
- Gill, Fraser, Anna – social workers and ASWs full time
- Lou - nursing student
- Nancy – information officer
- Hilary, Bea – administrators

I made fourteen visits over a six week period in April and May 2006. These included two team meetings, an allocation meeting, a shared learning session, and two half days on duty. Jane was away until Visit 4, both Sally, the longer-standing job-share manager and Wendy until Visit 6 and Anna until Visit 13. I interviewed eleven people: all four social workers, three CPNs, the occupational therapist, the information officer, the psychiatrist and the consultant psychiatrist.

A surface view of M Team

M Team's most defining features were its gritty 'front-line' feel and its professionalism. The sensation of being in the middle of a dirty, noisy and somewhat dangerous district was illustrated on my third visit when

'A Securicor van was pulled up just outside the office door with all its lights flashing. Its loudspeakers were broadcasting 'Help! Securicor driver requires assistance – call the police!' I saw a dishevelled woman inside the van speaking on her mobile. When I gestured towards her she shook her head, not wanting help. Once inside, the building seemed to shake with the racket and we could not escape it even on the third floor' (Visit 3M).

The team's professionalism started with their sensitive understanding of their client group, and the way they adapted their interventions accordingly. Most of their service users had put themselves at the margins of society. They remained elusive, shadowy and even nameless. Homeless people can be anxious that others will intrude on them with questions and searching looks (Foster and Roberts 1998). The workers were sensitive to this

'When we go to see some people on outreach, they won't even speak to us. Sometimes we don't even know someone's name. We just get to know them over a long time. There is probably an awful lot going on but it's all very kind of in the dark (Int 10M).

A lot of our guys have been out and about for many years avoiding getting noticed. That's been their deliberate policy – they're quite good at hiding their madness. It's not that easy to get to the bottom of what's going on' (Int 2M).

Their service users often had reduced intellectual and emotional capacity too. This was probably due to living for years on the streets, drug or alcohol abuse, borderline psychosis, personality disorders, or a combination of all these factors. It was during this placement that I began to understand the effects that emotional neglect and abuse

in infancy and childhood had on an individual's mental and emotional development. In fact

'The average life expectancy of rough sleepers here is forty two years. 50% have drug problems and 70% have alcohol problems. So we're looking at the extreme end of mental health with personality problems and social disadvantage' (Int 4M).

The consultant psychiatrist described them as having 'very limited and empty lives' (Int 11M) but they could also be volatile and occasionally violent

'He has a long history of very aggressive and verbally abusive behaviour but I have been quite lucky and have not been screamed at or had things thrown at me' (Int 9M).

'She has thoughts of stabbing people, she's an alcoholic and verbally aggressive' (Visit 6M).

The team had good support structures. They had put in place a number of regular discussion opportunities which gave them mental space to keep these shadowy and nameless people in mind. These included a weekly team meeting with a run through of all the problematic cases, the weekly case discussion and allocation meeting where referrals were discussed in depth, the monthly shared learning session, the monthly staff support group and their regular individual supervision sessions. Perhaps one function of the team's emphasis on reflection and discussion was an attempt to compensate for the intellectual impoverishment of their clients.

The following abridged extract from a duty observation gives some idea of their day to day work

Sitting in on Duty - Part 1

Wednesday morning from 9 am to 12.30pm (Visit 7)

1. To my relief Dave, the social worker manager, let me in from the noisy, dirty street quite quickly. I found Fraser and Gill, the two social workers, in the office with a smartly dressed woman whom I did not know, but who left shortly. Gill showed me the notes from yesterday. There had been no cases to carry over.
2. Gill talked to Dave about petty cash to find out what resources were available when she saw BB (the Congolese asylum seeker who had been mentioned at the Monday meeting). Gill had taken her in a cab across the city to temporary accommodation the previous day. Dave chatted to Fraser about a 1920s documentary on Portsmouth. Fraser said his great grandfather had settled in Portsmouth around then.

3. Gill telephoned a worker in another agency to let them know that one of their clients had called in yesterday. He had been rather confused and looking for medication. It sounded as if they were being defensive and she said 'I'm just letting you know', trying to find out how well they knew him. After putting down the telephone she said to Dave 'Not very good are they? Not seeing him until they have the medical report – he might be really ill!'
4. Hilary, the administrator, played back the ansaphone to take off any messages. Jane, one of the part time CPNs, came in, smiled and said 'Good morning' as she collected a file for her desk downstairs. Nancy, the information officer, came in. Dave asked her if she had anything for the administrative meeting - 'No we're up to date'. I noticed a small glass-fronted book case with all the books in a higgledy-piggledy state. I fantasised about tidying them – there was a note on the front of the case which said they were to be put in numerical order - but resisted doing this.
5. Fraser walked out of the room for a meeting. His whereabouts were already on the whiteboard. He left silently. I read that he had started the day with outreach visits at 6am. I realised this must have been the work which I heard him and Wendy, one of the two full-time CPNs, plan on Monday. Gill is typing away, getting her records up to date. I realise that I have not heard anyone in the team complain about record keeping. Nancy gives up trying to ring up about her next meeting as there is only five minutes to go, and decides to run for it instead.
6. Gill answered the telephone. It was Colin, the duty ASW. She passed it to Dave. Dave told him he had a gut feeling that we did not have to make a decision today. Leila (who was going to have a mental health assessment this afternoon) had telephoned Wendy, her key worker, the previous day to tell her that she had moved her sleeping site. Dave said that our message today was 'we're really worried. You are not very well and shouldn't be sleeping rough'. We would then offer her admission and the assessment team might be able to persuade her to come voluntarily. It would therefore be good to have a bed, but there was no need to delay the assessment. Colin told him he had booked a bed at St John's which pleased Dave. The conversation ended with some comment about Wendy and Ed, the psychiatrist, providing an 'alternative shout'.
7. Gill took a message for someone. She asked Hilary for some help with her computer which was playing up. Ed rang in. Dave repeated his conversation about Leila. Ed was trying to find Lou the nursing student. Meanwhile he and Peter were helping the client set up his television. Gill agreed to telephone Lou and check she was safe – where should she have been? Ed said she should be with him, Peter, the client and the telly. Gill spoke to her, but Lou could only receive and not make calls on the mobile. So Gill had to telephone Ed to say Lou was fine and on her way back to the office. Meanwhile Dave left.
8. All was quiet, with only Hilary, Gill and me in the room. I stood up to stretch. Gill could not access her computer records and started to talk to me. We chatted about the research project then I offered to make some coffee. When I returned and handed Hilary her coffee, I asked about some family photos which led to a conversation about her niece's illness.

9. The door bell rang and signalled a change in tempo. Gill wondered if it was BB for her 11am appointment. Hilary answered the telephone, taking a message. Lou bounced in, larger than life and excited. Lynne, one of the part time CPNs came in to tell Gill about someone who was running a pilot project in the community and reorganising things. Ed walked in and asked Lou what happened. She explained she had been five minutes late. She thought that they had probably gone in to see the client. She had sat on the doorstep waiting for one of them to telephone and tell her what to do.
10. Lynne told Ed about her plan to take her client Steve and his support worker to visit a nearby cathedral tomorrow. She said it had all sounded so reasonable when they were chatting to Steve that they had to go through with it now. Ed implied the visit might add to his problems around religion.
11. Meanwhile Jane was telling Lou about their planned visit to the day centre that afternoon with its karaoke and cans of lager. 'Cool!' said Lou. Peter, the other full time CPN who was also her supervisor, came in and asked her where she had been. Gill returned having talked to BB. She said BB had missed breakfast. Jane offered to get her a large roll. Lynne and Ed were still talking. Jane, holding a legal reference book, interrupted him with a quick question about Section 37.
12. Jane wondered if Wendy was coming back. She wanted to work out with her the two mental health act assessments which they had planned for that afternoon. These were for Jim, a client of Jane's, and Leila, Wendy's client. Ed was on the telephone. I heard him say that he had spoken to Dave and it was a chronic situation.

A reflective commentary - Part 1

Given the tension around getting into the office each time (one had to huddle round the intercom to hear it. I was relieved that Dave was able to let me in easily (1). It was my seventh visit and I was familiar with the lay-out, procedures and the staff group, so I was comparatively at ease.

I was interested to see how the team responded to BB, the asylum seeker (2). Dave had told the team on Monday that the local CMHT had been scathing when they heard that this team had accepted her and thought they had been duped. This information made team members keener than ever to help her. I was surprised to hear that Gill had escorted BB across the city. I was not sure if this was the level of attention which they usually provided or if the case was a novelty. Dave was pleased to talk to Fraser about something besides work (2). I had noticed that this was a deliberate part of the office culture.

Gill's comment to Dave (3) about another agency's attitude to its service user illustrated how professionally the team took its work. But it also provided an opportunity to project any hostile uncaring feelings on to the other agency rather than onto their own service users. Hilary quietly continued with her job of supporting the team members (4). Jane's warmth as she smiled and said 'good morning' was heartening (4). She included me in her greeting and I felt welcomed. Dave clearly worked closely with Nancy, his information officer, which strengthened the team's ability to portray its work favourably. I was definitely tempted to tidy the books (4). Perhaps I wanted to feel capable of classifying and making sense of something viz: the books, if not this team's task.

When I found that Fraser had been out since 6am (5), I was struck by the reality of the team's commitment to regular early shifts. I reflected that this commitment encouraged a self-selecting work group.

Dave's conversation with the duty ASW (6) about Leila's admission was interesting. Leila's situation had been discussed in detail at my first team meeting. I knew they were worried about her. Dave appeared to be attempting to set boundaries. He seemed to want to assess her under the Mental Health Act, but only to offer her voluntary admission. This implied that they would return another time if they needed to detain her. Dave did not make that clear. Perhaps none of them could think with clarity about Leila. This would account for the frequent discussions about her situation.

The difficult subject of Leila's assessment was shelved in order to try and locate Lou (7), a boisterous and good natured nursing student. She had started her six week placement with the team that Monday. Ed had a sharp and humorous turn of phrase, eg referring to 'the telly' as though a fourth person in the room. I was surprised to learn that mobiles could be arranged for incoming calls only, similar to some land lines. I noted that while such a mobile would be inadequate as part of a health and safety strategy, this technology could make a real difference.

Gill quickly filled the lull in activity with conversation (8). Perhaps part of the role of the group's lively interactions was to compensate for the 'dull and empty lives' of their service users. I had been aware that Hilary may have been finding my presence awkward, so welcomed the chance to have a chat with her and to get to know each other better.

After this, the office tempo changed rapidly when Gill's client BB arrived for her appointment: Lou burst in, Lynne came from the downstairs office to talk to Gill, and Ed returned from his visit. The picture of Lou sitting on the doorstep until told what to do (9) reinforced my image of her as a playful puppy, who, like all puppies, was providing a valuable diversion for the adults. She also seemed to absorb or divert some of the group's anxiety about being observed.

It sounded as if Lynne was having second thoughts about the outing she had arranged with a client (10). She appeared to be seeking reassurance from Ed, rather than guidance, as she then ignored his doubts about the focus of the trip. Peter must have asked Jane to provide suitable experience for Lou as Jane engaged her in the afternoon's plan to visit a day centre (11). Jane could not settle to anything and volunteered to go out and buy food for BB. When that was not taken up, she interrupted Ed and Lynne with a justifiable technical query.

I eventually realised that Jane's agitation was possibly related to the mental health assessments arranged for that afternoon (12). She particularly wanted to talk to her colleague Wendy who was involved with Leila's assessment.

Sitting in on duty - Part 2

13. Ed walked out. Peter was talking on the telephone about a diabetic client. He explained that the client was now physically well and had not taken anti-diabetic drugs for a year. Gill came back from her interview with BB. Lou stood by Peter's desk waiting for him. She seemed restless with nothing to do. Gill rang to find the whereabouts of the interpreter. The smartly dressed woman (who turned out to be the Senior House Officer, SHO, psychiatrist, and came in two half days a week) returned to join Gill. They planned to interview BB jointly. Lou tried to open the book case for something to read but found it locked. She asked Hilary for the key but they could not find it (so much for my fantasy).

14. The SHO and Gill discussed BB's drugs and medication. Gill said that as she was in a stable placement BB wanted ... (Dave and Peter left for supervision) ... plenty of money to top up her mobile. BB was getting support from Medecins Sans Frontieres and also from a church some distance away. (Lou began to peel an orange). They agreed to look at practical issues in this interview. When those had been addressed, they could discuss the future. Would it be a life sentence in 'bed & breakfast' accommodation? Or would she get asylum for her trauma? The SHO hoped that she would.

15. Gill agreed to focus on the social side. She tried to locate some food vouchers, and learnt that their provision was being discussed at a meeting the next day. She had been impressed that BB had arrived for her appointment on time. They would do a Community Care Assessment. Gill went to explain to BB that they were waiting for the interpreter.
16. Fraser returned and talked to someone on the telephone from Street Services. He and Ed had seen the person they were talking about the previous day. He was a wanderer and slept in different places. They had drunk coffee with him at 10am. He had been clear-headed and making sense (not yet drinking) so they had access to his mental state. This was the fourth time they had seen him. There had been no evidence of mental illness on any occasion. He said he would get back to her.
17. I asked Fraser about his early 6am outreach visit with Wendy. He said they had been looking for the 'silver trolley lady' but could not find her. They had seen Julie but she had just said 'Go away'. There had been no sign of the other two they had hoped to see. So they had breakfast at 8am before coming into the office. It had been lovely at that time of day – even the railway station looked fresh and rosy.
18. Lou came back. Jane was repeatedly walking in and out and rather restless. She persuaded Lou to eat her lunch in the kitchen. Dave came in and offered to get lunch for Hilary. He rearranged the supervision time with Fraser. Dave went to the downstairs office, where Jane and Lynne sat, to tell them there were no clinicians upstairs, only Hilary and me. Lynne walked in with an enormous pile of files saying that she would start duty as Gill was running late. Dave came back with sandwiches for most of the office. Everyone took some time off, mainly looking up information on the web. Lynne helped Dave to translate different sailing boat accessories from German into English.
19. Jane came in to check with Dave about the arrangements for Leila's assessment. They talked again. Dave appeared to be reassuring her that there would be no final decision about using the Mental Health Act if she agreed to admission. There was also the hostel place to offer. Dave reiterated 'There's no pressure so it shouldn't be too difficult...' I thought he was reassuring himself.
20. Nancy told Dave about a new computer programme that would help with their progress notes. Jane sent a fax from the machine near my desk and asked if I had eaten lunch. I assured her that I had eaten my sandwiches for elevenses and we laughed. Gill came to collect a printout of clinics for BB, having sent her off to a lunch club. She planned to take her to Tesco afterwards.
21. Lynne answered the phone to someone who said he was a solicitor. He urgently wanted a letter from the team to support bail for a client. She remembered there was media interest in this client last time. She and Dave found a letter on the file from the previous Thursday. Dave said he was not going to be bounced into replying in twenty minutes – it just wasn't on. He suggested she told the caller that none of the people working with the client were in the office at the moment. But if we could confirm that the caller was genuine, we could fax the letter. I left them to it, saying goodbye to Nancy, Hilary and Lynne.

A reflective commentary - Part 2

Peter (13) was acting as advocate for a diabetic client. The team were required to do a considerable amount of advocacy as other agencies had concerns about their service user group. Lou stood beside him, waiting for something to do. When she attempted to get a book to read, she was locked out. The books were not only disorganised but also unavailable. I wondered whether 'knowledge' was too precious to be left unlocked or was there a risk that other people might look too closely and question its worth? I had previously been struck by the team's lack of interest in the paper presented at the shared learning session. It appeared to imply a suspicion about different points of view.

The SHO and Gill worked out their different roles in the planned interview (14, 15). While BB's experiences might have induced post traumatic stress disorder in some people, none of the professionals could predict what the Immigration Office would decide. This meant that their planning had to be as short-term as the clients. I was conscious that this was the first team in which I had seen staff coming and going to supervision (14, 18).

I was surprised when I heard the high priority BB put on her need for money for her mobile telephone. I reflected that mobile technology had changed expectations on the ease and frequency of social contact right across the globe. The need to have an interpreter to help conduct BB's interview (15) demonstrated the demands and complexity of conducting assessments for non-English speakers from around the world.

When Fraser discussed a client with a colleague, I was struck by the effort they had made to be alongside the client in a way that he could tolerate (16). This resulted in a thorough assessment of his mental state – more than that given to many more orthodox patients.

Fraser gave me a vivid description of his outreach work that morning (18) – the difficulty in finding people, their namelessness, the single 'Go Away!' Then he described his sense of a city washed clean by the dawn, which seemed to stand in contrast to their intractable client group.

Lou returned far earlier than expected. We were all relieved when Jane persuaded her to eat her sandwich downstairs in the meeting room. Dave saw it as his responsibility to make sure everyone was sustained (18). As a manager, he may have felt it was part of his contribution to a good working environment similar to his interjections on non-work issues (1). As Hilary was answering the telephones (her colleague Bea must have been off for the day) he added her sandwich to his list.

Dave also took responsibility for the health and safety of staff. He had explained to me that their policy was to try to have two clinicians in the building at all times (18). As Gill was still interviewing, he asked Lynne to come to the office. When Dave returned with lunch, people took ten minutes out of the day to read or search the web for personal information unrelated to their work.

Jane at last had managed to track Dave down (19) and to ask about his plans for Leila. Wendy had not yet come in to the office. He reassured her, but clouded the issue by mentioning the fall-back possibility of a hostel place. I wondered why Dave offered multiple and contradictory solutions – assessment but no compulsory admission, a hostel place, voluntary admission, Leila is in good contact with her key worker, we must act today etc. Perhaps it indicated conflicting views between team members? I could not quite place Jane's anxiety and involvement as Leila was Wendy's client.

Jane, despite her worry, had time to worry about me. I felt touched when she checked that I had eaten (20). When Gill sent BB off to one of the lunch clubs available, I was again surprised at the network of resources available to homeless people on the streets.

Lynne had to deal with a suspicious telephone call (21). Fortunately she remembered that the press had been involved before. She handled it cautiously and asked Dave's advice. I admired the way that they resisted acting too quickly but responded thoughtfully and with care. This corporate memory was a central component of the team's ability to provide a service for their service users. I decided to keep to my time boundary, but was conscious of much uncertainty in the air when I left.

What is the emotional meaning of the work?

During the morning I had the opportunity to observe the care, thought and creativity that went into all aspects of the team's work. I saw the warmth and nurturing that was a significant part of their culture - with its ritual of fetching each other food and drink and their shared conversations. It formed an important defence against the harsh streets outside. The banter and office friendships seemed to compensate for the bleak lives of their clients.

However, their need for group cohesion appeared an important defence against some primitive anxieties prompted by the work. The following account of my counter-transference experiences throws light first on the fear of a critical gaze felt by the group and by the service users. The other emotional concern in the group related to a fear of exclusion and being an outcast from the group as shown by the case spontaneously brought up in three interviews and evidence of other incidents.

Counter-transference insight

My first observation visit was to the Monday team meeting. The team were discussing applications for a hostel vacancy, where one of the applicants was said to be violent and unpredictable. I found myself in an unpleasant reverie. Rather than listening to the discussion, I was preoccupied with a difficult situation at home which had left me feeling damaging and incompetent. This stray thought of mine (Ogden 1982) may have been a counter-transference experience to give insight into one of the group's concerns. As I learnt more about the team's work I realised that they often felt damaging when trying to help their clients. They were preoccupied with the dilemma of having to act in a punitive way for the client's long term good.

In the break Dave shared how anxious he felt with my presence at the meeting. He wanted to interject and put everyone's comments into some sort of context. He explained that Ed, the psychiatrist, often spoke frankly and he did not want me to get the wrong impression. I attempted to reassure him. But in retrospect it would have been more helpful to have acknowledged his discomfort (Visit 2M).

At the end of Visit 6 I forgot my notebook. It was left amongst some papers on the spare desk. On my return I found an unsigned note slipped between the pages 'Please do not leave this around, it makes us feel paranoid'. My forgetting the notebook and their reaction to it illustrated the strong persecutory dynamic in observing and being observed.

I endured several uncomfortable sessions of which my final piece of observation was typical

'...at this point (about half an hour into the meeting) there was some complex banter and sharp remarks (I think Ed said something OTT about another member of staff) – people looked at me to see my reaction – was I writing it down? I felt very intrusive and uncomfortable and deliberately put down my pen for a bit.

Twenty minutes later the quick talk became quicker and Ed made a sharp in-joke about Fraser that I missed. Everyone looked at me to see how I'd reacted. I said – 'I missed that' and put down my pen and stopped writing. The meeting came to an end. I mentioned that it was the end of Part One of my research and there would no more observation' (Visit 9M).

The group eventually pressured me to stop making notes. I felt compelled to put my pen down, unable to continue recording due to the intensity of feeling in the group. The group used Ed's sharp tongue to attack me as the outsider, just as they used him to express their frustration with their clients and each other. I could not continue. I told them that this was my last piece of observation. That evening a friend asked me 'Have you finished your surveillance yet?' precisely articulating M Team's emotions.

What was all this about? Admittedly being observed is never comfortable. Healy (1999) points out 'Being observed, especially if we are being observed in a crisis situation, may evoke the feeling of dread that what we are doing is wrong and will be exposed to the world for critical judgement' (p54). And again on audit, 'Superego type audit activity is characterised by a dread or terror in those being audited of being found out, being criticised and being harshly judged' (p55).

But the Mental Health Team were working with a particular group of service users who were more than homeless. Gilligan (1996 cited Adlam & Scanlon - 2005) suggests that 'such people are made to feel ashamed, not only of what they do, but the deeper wounding of being ashamed of who they are: literally ashamed of their self' (p457).

Steiner (2006) reminds us that 'humiliation is an important part of the threat coming from superego figures' (p941). Observation had therefore a particular emotional meaning for the Mental Health Team which was managed sensitively for their clients. I had no such dispensation and felt the full force of their projections.

Being excluded and an outcast

Leila

People are inclined to bring situations which they cannot think about to the attention of someone whom they feel can help. Interestingly the Mental Health Team brought Leila to my attention in several ways. Her situation had been discussed at my initial visit when I recorded

'Ed described Leila as having chronic long term psychiatric problems but she was always very pleasant and undemanding. She came up from the coast and has been rough sleeping for the last six months. While there may have been hospital admissions in the past, she was last seen by a locum psychiatrist who said there was not enough evidence to admit her. Leila presents well but must now be quite ill. She is being referred for a Mental Health Assessment now which needs to take a long term view.'

There followed a very full discussion with all eight members of the group participating. Dave asked what would we hope to achieve by admission? Was there a risk of her running off? Ed thought so. Dave thought we should be straight with her and 'share our concerns'. Ed said 'She'd scoot! We could easily be the latest mental health professionals to be evaded' Gill described how Leila greeted them with a kiss – Ed said he felt like 'a real Judas' (Visit 2M).

It was evident that Dave's question 'what do we hope to achieve by admission?' was never answered. By following it with a query on the client's evasiveness, Ed had an opening to emphasise their need to be persistent. However, completing an assessment in such circumstances could quickly become persecutory. The dilemma and pain for the professionals in continuing to act in the client's interests is vividly captured by Ed's description of feeling 'a real Judas' when the unsuspecting client kissed him.

When Leila's key worker, Wendy, returned from holiday the assessment became a priority. But Jane, who had also been away at that first meeting, appeared ill at ease with the proposal, as shown in the observation above (Visit 7M). I was unclear why.

Two weeks later I was in the office (Visit 12M) to interview Ed and then Dave. Apparently Leila's planned assessment had not taken place as another was arranged for that afternoon. I noted a sense of foreboding in the air. When invited to talk about 'a difficult situation.' Ed brought up Leila

'Wendy and I've been concerned about her for a long time. And I feel every time we discuss it, it becomes a bit clearer in my mind because of our discussion. I have talked it through with a number of people because that helps to clarify things a bit. Hopefully it will be resolved one way or another shortly - or maybe not. For this situation we would try to get a female psychiatrist. We think that's more appropriate' (Int 4M).

Ed did not really explain why he and Wendy had become so worried about Leila. They usually worked carefully to fit in with the longer time span often needed by homeless people. Perhaps she came over as different from the other rough sleepers with whom she associated? Perhaps she seemed older or more middle class? I was relieved that they wanted to find a woman psychiatrist for a second opinion.

Dave was also worried and perplexed at the situation, particularly its impact on relationships in the team

'There is an assessment which has been rumbling on and might be happening this afternoon. There are a lot of complicated issues within it and potential for conflict within the team and outside the team in terms of relationships, in terms of how decisions are made. One person said in the team meeting "Are you aware that I am feeling like this about it?" There is a slight sort of trickiness there. It is a slightly no-win situation'.

'I am aware there is a danger in a team like this which has a shared ethos and low turnover and has very good informal systems and a lot of friendship between individual team members. I think that all those things are healthy. But I think that probably if someone is coming into the team they might be struck that it might be slightly excluding at some levels. That is slightly happening here. I don't think there is a neat solution to that' (Int 5M).

Dave was clearly concerned as to how the group would respond to this challenge. I was glad that he mentioned the disadvantages of close-knit teams for newcomers. I noted he had not yet discussed his concerns with the unnamed team member. I thought he was referring to Jane. Perhaps that was why Jane was supportive towards me, realising I was another outsider?

I was in the office the next day (Visit 13M) to interview Fraser and Nancy. Jane was on duty and asked Dave what had happened the previous day on Leila's assessment. Did

it go ahead? Dave explained that the ASW had agreed she needed treatment for a psychotic illness. Jane was surprised. The psychiatrist and Wendy were both trying to obtain her agreement to go into a hostel rather than to be admitted. Leila had even said to Wendy 'You're more upset than me'. Dave said that they had never planned to do an admission then, and had not wanted the trauma of the police and ambulance. That could be handled later. Jane attended to telephone calls and paper work, muttering in consequence of one 'This is a horrible situation!'

The following day (Visit 14M) I interviewed Jane. As the only black clinician in the team, I had wanted to affirm her work. I asked her if she could tell me about something recent that had been quite difficult.

'Well, I have just come out of something that is quite tricky. There is a lady - a black lady in her middle age. She has been rough sleeping for some while. People have been quite concerned about her. To cut a long story short, I met her at the day centre and said to my colleague that on the face of it she does not seem acutely unwell, but she is acting in a way that is unusual for a woman and lady of her age in her mid-50s.

After a few weeks it was decided to do a mental health act assessment to get her assessed. That happened yesterday. All along I was saying "What will we do if we do section her?" A lot of black people, rather than being informally admitted or offered a different type of treatment, are sectioned and it is often their first contact with the mental health services.

I am really worried because I have been involved in this work for years and years and I know what happens to black people when they do go into hospital. This lady has never been in hospital before. Why are we doing it with this one? I am not happy about it. But I don't really want to rock the boat. I feel very visible anyhow because as you can see I'm the only black clinician in the team. I do not want to alienate myself from my colleagues' (Int 8M).

Jane was the first person to mention that Leila was black. I wondered why, and concluded that it must be a policy not to include racial background in descriptions of cases. It was also noticeable that while Ed had mentioned the benefit of using a woman psychiatrist, no-one suggested using a black clinician as key worker.

During the interview I became convinced that the team were proceeding wrong-headedly, and that Jane as a black woman understood the best intervention. Later I realised she seemed to have reordered the narrative so that it was she, Jane, who had met Leila through the day centre, rather than Leila having been Wendy's client for the last six months. She also 'forgot' talk of past hospitalisations. Just as she convinced

me, so she had convinced herself of the importance of being the allocated mental health worker.

Leila, like several clients, behaved in a conciliatory way to ward off conflict. But Dave was also conciliatory. He worked hard to avoid or defuse conflicts with other agencies eg 'it would only irritate the hospital if we closed the case now, so how about suggesting a case conference?' (Visit 3M). Recognising the group's excluding closeness, he could have sided with Jane. Together they could have made the case for reducing the statistics of compulsory admissions for black and minority ethnic (BME) patients. But at this moment, he did not. The team's stable membership had many advantages in terms of knowledge and professional practice. But on this occasion it worked against recognition of internal differences. Race was rarely mentioned in the team, and Jane's feelings of exposure were understandable. Her overt 'softly, softly' approach was different from the mores of the team who reputedly talked through conflicting views to reach agreement on the way forward on a case.

However unresolved conflict was more common than acknowledged. Incidents of difference and exclusion emerged in interviews and related to both personal and professional issues. Gill was unhappy that her social work student had been excluded from the monthly support group. She failed to convince the members that a social work student on a six month placement was in a different position to a nursing student on a six week placement. Fraser was disappointed that the manager accepted that a client of his, a young black man, was unexpectedly refused a place in a hostel. Julia, the occupational therapist, disagreed with her manager on the benefits of admitting an older man into hospital for assessment. It was probably a relief for the group when they all agreed how poorly another team responded to 'no recourse' cases.

The team's therapeutic task

Adlam and Scanlon (2005) consider that anyone working with homeless people have to engage with the structural violence of exclusion and coercion at the expense of social cohesion and co-operation. Teams risk being engulfed by the projections received from clients and 'splitting into dismembered and fragmented states' (p456). They argue that the staff are often reluctant to take up membership of their respective professional groups as the team - fragmented into professions - might be overwhelmed by the chaos

associated with their clients' fragmented state. This is relevant to M team as they rarely mentioned the different professional disciplines from which they came.

Their task was to 'house' the homeless mentally ill both psychologically and practically. But society, as demonstrated by the media, consistently associates violent and dangerous images with the homeless, which adds to clients' fears of disintegration. One social worker objected to the distorted practice that this created

'It's the way the media is felt in the organisation. Everyone wants to be blameless. No one wants to take any risks – but I don't like being risk averse and driven by this sort of blame culture – covering one's back. As long as you can justify your position and explain why you have done what you have done and have a good rationale behind your actions, then you are not behaving negligently' (Int 3M).

Some of the clients have been put on the margins of society by government policy. The mental health workers have to carry ambivalent attitudes for society. For example, they were unhappy at the system expected to be operated for failed asylum seekers with no recourse to public funds

'You want to help her or do something, but really you can't do anything. I do feel it's a very discriminatory system. We are stigmatising them by giving them handouts, vouchers which identify them as asylum seekers. It is really unpleasant. I think the whole thing is very unpleasant. I'm sure they feel persecuted quite often' (Int 3M).

Rustin (2005 p16) stressed the pressure such conflict put on workers when she looked at Housing Department staff having to assess illegal or unwelcome immigrants for accommodation, in her comments on the Victoria Climbié Inquiry (Great Britain 2003).

When I asked team members to talk about a difficult situation, each case mentioned had at its heart a dilemma to which there were no clear answers. For example: Would a mental health assessment be in the client's best interests? Would it seem punitive? Would the client disappear? Will hospital admission do any good? Should we just cover ourselves in case of a press inquiry? How will clients cope on a noisy acute ward after the solitariness of rough sleeping?

Would discharge this week obtain the best hostel placement for the client, or would discharge in two weeks time be better? Will the tribunal discharge the client when there is no placement organised? How do you tell a client prone to aggressive outbursts that their case is being 'closed' after 5 years? Is it best to do face to face, or would the hour

long journey to the office make this seem persecutory? In that case how do you write and tell the client?

Some policies failed to reflect the need of the group they were meant to help

‘One chap has had alcohol problems and schizophrenia for 25 years and we got him into a staffed hostel and he is a lot healthier and physically and mentally stable. But he is only allowed to stay three years, so we are worried now where to place him’ (Int 6M).

Reflecting on the diverse, and difficult issues that faced the team every day, their need to provide as much cohesion and support to each other as possible is understandable. But the confident exploration of professional differences could have ultimately added to the team’s strength (Borrill et al 2000) and provided a role model for other multi-disciplinary and inter-professional groups.

Space to think

M Team were recognised to be working with intractable, and occasionally dangerous people. Many had borderline personalities or could be classified as having a personality disorder as well as being psychotic. The team were able to give these service users support beyond the food and shelter provided by local voluntary organisations. The working week was structured both to keep the service user in mind and to provide space for the team members to think and reflect about the work.

Learning from each other

During the working day the mental health workers regularly checked out with each other about client issues such as new duty cases, work planned together for the future, or what line to take with another agency. There was informal discussion on the groups attended, and the people seen. The team were committed to having at least two clinicians in the building at all times. This was for health and safety reasons, and emphasised the shared nature of the work. They went on outreach visits in pairs, and reached assessment decisions in partnership with another mental health worker. Steps along the way were developed through constant debate and discussion

‘On hard decisions you feel they are really discussed and everyone has a chance to say what they think. People do not feel because they disagree, they don’t feel they shouldn’t say that. It’s good that the medical team and the nursing staff and

social workers meet together and talk through things. In some other services the medical decision is final, whereas here it is more as equals and we make a team decision' (Int 9M).

The team successfully addressed these issues by having a twice weekly meeting. New cases were discussed, and old and problematic cases were booked in for review. This system illustrated the group's openness to new ideas and creativity, and had been suggested a couple of years earlier by an Australian locum. It was effective because the meetings were well run, and all the staff attended and contributed to discussion. They used these opportunities to think about and debate many problematic issues. The consultant psychiatrist attended these meetings. Staff consulted him individually on particular cases after the meeting. He was away for most of my placement, so appeared a rather marginal if reassuring presence.

Supervision

M Team was the one team where the supervision structure was well maintained. The managers enjoyed providing supervision. Appointments were included on the daily movements on the whiteboard. The team had made it a condition of the placement that I would not observe supervision, so I did not feel that I should be trying to attend. Views varied as to its value as a reflective process or mental space. The interviewees saw supervision as a necessary management tool, often describing the joint decisions which they and their supervisor made on their cases. One commented that

'I get supervision which is okay. I get that from one of the managers. It is more managerial supervision and case management stuff. I get my emotional support from my husband and informally from the team. If there was something that was troubling me I could talk to the team. I don't necessarily need a formal forum' (Int 2C).

There was also a sense that the space was sometimes used by the manager to assert their authority and to influence the worker into agreeing a course of action with which they were not entirely happy

'He has been sleeping out for probably at least 10 years. He's very entrenched. There is nothing obviously mad about him. There are no obvious psychotic symptoms. He is not particularly depressed. He is quite jolly in many ways. He's very very stuck.

When we were reviewing cases, my supervisor thought that maybe we should think about a mental health assessment because he is not getting anywhere. I don't really want to do that. I have kind of said that I am not really happy to do that. I do not see any justification to do that. He is just one of those interesting characters who do not really fit into any niche' (Int 11M).

Training and development

The team was a good example of a 'learning organisation'. For example, the fourth social worker in the team had just completed his Approved Social Work (ASW) training and received his warrant to practice in my first week. For the first time all the social workers in the team were ASWs. At least two of the CPNs were completing further academic courses, another was training as a psychotherapist. The psychiatrist was also in a training post.

The creativity of the information officer, the lead administrator, had spin-offs for the team. She had been praised for the quality of her statistics and reports. This helped the team maintain a good reputation with its commissioners and colleagues in the field. The rest of the team were motivated to produce information in a timely way. They had also devised a presentation which explained their work that any team member could take round to other agencies and colleges, or for use in training.

The work was varied, with opportunities to provide advice and support to hostels, 'street services' teams, and drop-in centres - as well as training for main stream social care and medical services. Staff enjoyed the role of supervising students on nursing and social work courses. It seemed to help them reappraise their work while they developed broader skills. The team had also established a monthly learning workshop held jointly with the psychology unit. People presented papers in turn and led discussion.

Conclusions

M Team worked with difficult clients with psychotic symptoms, borderline personalities and personality disorders at the margins of society. The team had good support structures and maintained regular and supportive team meetings. This gave mental space to keep their clients in mind. The team's reflective culture formed an important

defence against the harsh environment of their clients. The challenge of helping clients often required the team to take difficult decisions in the long term interest of clients.

However they did have difficulty in admitting to differences within the team. This helped them to survive projections from their service users. But it risked limiting their development eg in becoming a more ethnically diverse team to reflect their client group.

M Team were highly motivated and demonstrated the capacity available in a front line team if adequate space is provided for thinking and reflection. They also demonstrated the learning opportunities derived from working in pairs. All outreach work was with a colleague, as were formal assessments. Familiarity with having one's work observed probably facilitated frank discussions in the team meetings and case discussion group. This fed into a virtuous circle of reflexivity, creativity and articulation.

'You get the chance to do so many different things, like support for other services and training. I think the reason that people stay is not just the client work but the team. We work very well together as a team. I think that people come back. There are quite a few people who have come back to work here. I think that is a real testament' (Int 9M).

If the work of other social work or multidisciplinary front line teams was taken as seriously by employers, the outcome could be highly beneficial. With space to think creatively, and with recognition and support, the whole ethos of social work could be enhanced.

Chapter 7

What supported or impeded creative problem solving in the three teams?

‘Out of the crooked timber of humanity can no straight thing be made’

Kant 1784

Introduction

This chapter investigates the heart of my broader research question developed during the analysis of the material: what supported or impeded creative problem solving in three front-line teams? The chapter puts the analysis into context and looks at the research relationship which I built up with each of the teams (Fig 7.1), the different incidents which may have had some bearing on the experience, and the project’s impact on the teams.

Based on the observations, interviews, counter-transference and my previous experience, I explore the effect the adult service users had on the teams and individual workers. I noticed two particular groups which preoccupied them: vulnerable adults at risk of abuse; and service users who display the traits of a borderline personality acquired through neglect or abuse in infancy.

The teams are then compared across the five key enabling factors (signposted in Chapter 3) which I discovered to have impact on the ability of social workers to engage in creative problem solving: coherent policies (both national and local); professional development; mental space; autonomy; and support structures. I take each enabling factor and look at both the emotional pain and the surface issues evidenced in the teams.

The researcher’s relationship with the teams

To remind the reader of the different staff groups and different contacts with the three teams, I have reprinted Figure 3.1 (see Figure 7.1 below) and compare the different

emotional meanings with which each team had to work. As shown in Fig 7.1, it was more of a challenge to become engaged with H Team. This was due to a number of causes, in particular the structural layout of the office, the break in my visiting while waiting for COREC (NHS ethics) approval, the sickness of the service manager, and my own discomfort in the hospital environment which was emphasised by the death in my family. From this experience I learnt the importance of establishing a good relationship with a link person, and the reassurance provided by a temporary place to sit. I negotiated these in M Team at a preliminary meeting with the job-share manager, who was my link person. This did not remove the intensity of the team's projections, but helped me to manage them robustly.

Reflecting on my work in the three teams, it appears that the role of the researcher in observation and interviewing has a significant effect on the team. As in infant observation, I found the teams would bring their insoluble problems to the researcher if she gained their confidence by being reliable and interested but uninvolved. This happened with D Team when they shared examples of impotence and lack of autonomy. By interviewing all staff and holding them in mind, I helped them to find the mental space to reflect, articulate, and take creative action to overcome their feelings of impotence. Although I interviewed fewer members of M Team, they still took the opportunity to talk of some unresolved conflicts around different professional approaches to the service users, despite the fact that everyone 'got on so well'.

In H Team the insoluble issues of depersonalisation and of lives falling apart appeared to be acted out rather than talked about - just as in their work with service users. The team's management fell apart and the researcher remained on the margins. It proved harder to be an independent, reliable, and benign presence in this team for the practical reasons mentioned above, and perhaps because of my involvement with the team's unconscious issues.

Fig 7.1 the multiple-case study structure

Variables	Case 1 D Team	Case 2 H Team	Case 3 M Team
Negotiation process	Emailed proposal to director, principal officer invited me to management meeting Feb 05. There, service manager D team and operations manager H team invited me to their team meetings March 05. Teams unanimous in agreeing to research. Agreed to start with D team April 05 and H team September 05.		Attended regional meeting of lead social work managers. One passed email proposal to manager. Met team in May 05, agreed to project, excluding supervision. started March 06.
Part 1 Psychoanalytically informed observation visits	6	6	6
Part 2 Ethnographically informed Participant observation visits	10	8	8
Interviews of embedded cases (staff)	20	6	11
No. of staff	21 (3 managers, 14 soc workers, 1 specialist worker, 3 admin)	22 (4 managers, 12 social workers, 2 specialist workers, 4 admin)	18 (2 job-share managers, 1f/t psych 1p/tSHO 1p/t cons psych; 2 f/t 4 p/t CPN; 3 f/t swkers; 1 f/t OT; 3 admin)
Factors to promote engagement	Interest of team members, link person; seat in open plan office, use of kitchen, familiarity with setting, interview everyone.	Interest of team members, initial link person, keenness of managers, kindness of temporary administrator.	Interest of team members, link person, seat in open plan office, use of kitchen, my increased research experience.
Factors to inhibit engagement	Time taken to establish a rhythm to the research.	Break in visits for COREC approval. No link person as the managers left, no seat in small offices, no use of kitchen. Ward focussed.	Group hostility to being observed in Part 1.
The emotional meaning of the work	Fear of mental and physical disintegration and impotence SO Supported people in community to counteract their loss of autonomy	Desolation and despair in face of death SO Held things together for people when their lives were falling apart	Fear of exclusion and becoming an outcast from the group SO Provided mental health and social care to aid client inclusion
The impact on the team	Stuck, difficult to introduce new ways. Victims, like their clients, felt exploited by other teams. No flexible use of staff	Staff ignored the pain, delivered on target and got good feedback. The managers wore out and left. No flexible use of staff.	Difficulty in discussing professional and personal 'difference' eg race and in confronting other services. Flexible use of staff when their circumstances changed.
The impact on the researcher	Felt at home with staff and client range. Used the team as a pilot and interviewed all staff.	Struck by lack of individuality of older people. Had difficulty holding my own life together.	Tried hard to be the 'professional' researcher. Easier role once official observation finished.
The use made of researcher	Through being 'held in mind', team introduced case discussion group which increased group cohesion, creativity and learning opportunities.	Researcher remained on the outside. The managers all left the team (no follow-up).	People shared areas of difference with researcher (no follow-up).

What was the service users' influence on creative problem solving in the three teams?

The mind is a city like London,
Smoky and populous: it is a capital
Like Rome, ruined and eternal,
Marked by the monuments which no one
Now remembers.

Delmore Schwartz 1959

Cooper (2005) in his critique of Lord Laming's statement that social work is 'a combination of professional skills and personal qualities' considers it rather

'the capacity to endure emotional and intellectual pain and simultaneously exercise measured thought, analysis, and judgement' (p155).

This is an apt description of the parallel processes which I want to examine. In considering the impact of emotional pain on the social worker's judgement, I found as I explored daily life in the three teams that the emotional content of the work could be experienced at two different levels – that which team members were aware and that which they were unaware, or took for granted and paid too little attention.

Illustrations of the latter include, for example, the way the District Team held a sense of the evil aspects of life simmering just below the surface, with the fear of drowning in the work and becoming impotent like their service users in the face of these threats. Similarly the Mental Health Team compensated for its fear of being scape-goated and ostracised by the group - fear projected into the team by their mentally ill homeless clients - by avoiding conflict and creating a friendly atmosphere. The unconscious echoes of death, fear of dying and disintegration were close to the surface in the hospital. I was struck by the coincidence of observing isolated older people while concerned about my own relatives. The elderly lady 'like a little sparrow' (p107) remained uneasily in my mind. Her plight prompted me to look closely at the unconscious issues in the teams to learn and understand about dependency and ways of reducing the risk of abuse. I also wanted to think how best to work with those service users with borderline personalities who were prevalent among the more challenging clients in the District and Mental Health Team. In addition I wondered how social work went about 'counteracting disintegrating forces in individuals, families and localised social groups' as noted by Winnicott (1965).

Dependency

Woodhouse and Pengelly (1991) comment that

‘social workers are caught up in society’s own profound ambivalence about the care of its dependent members, whether children or adults’ (p187).

The situation in recent years has become more evident. Hoggett (2000) wrote

‘There is a deep-seated hatred of dependency within our culture which needs to be understood; I fear that otherwise it will leave an irredeemable scar upon the project of creating a better world’ (p166).

He reminds that by being human, we are all emotional and vulnerable beings, and considers those occasions when

‘We struggle not to be overwhelmed by feelings and, to the extent that we cannot find the inner resources to contain and give meaning to what we experience, we depend upon others. We depend upon them for reassurance and empathy, to show the strength and confidence in the future that we ourselves cannot at that moment find or just, simply, to be there, reliably and attentively, with us. We call this care, something all of us give and receive’ (p164).

Dartington (unpublished 2007) notes the tension between the paranoid-schizoid response to an incident - that of the hero fighting back - and the depressive stoical acceptance of learning to live with the good and bad in the world. He suggests that health and social care services need to work with both of these. Cooper and Lousada (2005) consider that society’s fear of dependency poses a danger to itself

‘It is not dependency that is the problem, but fear and hatred of dependency, which destroys the link to the source of support that may be the ground of our well-being’ (p195).

Perhaps it is due to fear of our own anger and hatred towards those who by their dependency demand a response that we and others in society avoid and marginalise these needy groups. Winnicott (1947) suggests that psychiatric practice could benefit if psychiatrists and mental health staff were in touch with the hate and fear of their psychotic patients that was projected into them.

‘However much he loves his patients he cannot avoid hating them and fearing them and the better he knows this the less will hate and fear be the motives determining what he does to his patients’ (p195).

Sixty years later, staff in our mental health services and services for older people can still benefit from this sympathetic insight.

Many social workers are not only ambivalent about the dependence of their service users, but also ambivalent about their own interdependence - being reluctant to seek or use support at work. The relationship between authority and support is often tangled with echoes of childhood strivings. This has implications for the provision of effective support in the workplace.

I thought how difficult it would be to engage with someone who could not relate back. But I knew many people were able to do just this. Perhaps they found their own level of communication through small signs from an unconscious, brain-damaged, or dementing person. I reflected on the way different people's individuality can engage us, eg my concern for Mrs Y in the District Team (p86). Physically dependent people recruit help through their own personalities. One social worker in D Team summed this up 'They may be disabled but they are very alert mentally.' This skill is vital if service users are to protect and to preserve themselves. I remembered Troy, aged six, abandoned and speechless in hospital with his limbs confined to prevent self-harm from chronic muscle spasms. I was a young nursing auxiliary and taught him to stick out his tongue at the matron. When I visited six months later he greeted me with a wide grin and stuck out his tongue.

I had no conception of the Hospital Team's work until I visited the wards. I was confronted with the early deaths of patients with cystic fibrosis, the loss of limbs through gangrene, the despair of the elderly woman, the lack of identity of the patients, and finally the overwhelming sense of vertigo as the team's management fell apart in front of me (described in Chapter 5). At these times I was in touch with our shared unconscious (see Figure 7.3 p152).

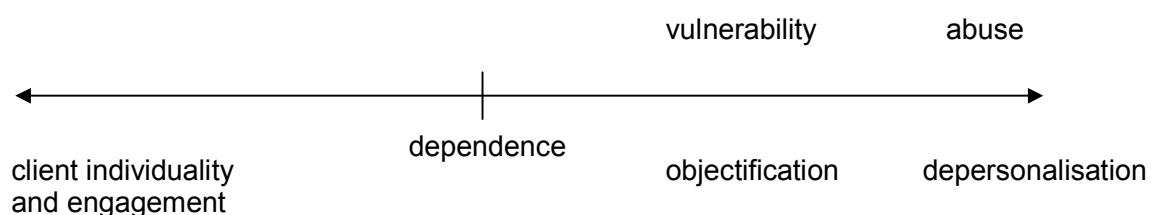
A social worker described the difference the hospital environment made to engagement with a service user

'In the District they get the chance to read files. They make their own appointments. They can go out. They can see how patients operate in their home. That is an advantage. But here you just see somebody in a hospital nightie propped up in bed or in a chair. They can tell you anything they want to. And you can't verify it' (Int 2H).

Another, quoted earlier, 'found it hard to get a handle on their lives in this rapid moving hospital situation' (Visit 2H). 'Old hands' enjoyed the thrust and parry of challenge with hospital staff. For example, they would occasionally insist on a service user's need to stay in hospital until he/she had recovered more strength. Terry, Mike and Kelly demonstrated this. But newer social workers did not have the experience or internalised sense of professional identity to challenge the medical and nursing demands for discharge reinforced by the Delayed Discharges Act. So while social workers in the District Team were energetically helping their clients to avoid institutional care (eg Marlene's tale), or seeking the best personally tailored alternative, hospital social workers were required to ignore the individual's plight and comply with the legislation. When I read of a pilot project in another part of the country to employ volunteers to act as advocates for older people in hospital, I feared for the integrity of the hospital social work service.

I wanted to express the dynamic flow of a client's dependency needs – the way they change and increase with age but also decrease for children as they grow and reach maturity. In Figure 7.2 below I have drawn a horizontal axis to represent dependency and the service user's expressiveness and emotional situation. I have put service users who possess individuality and the ability to engage with others at the left; noting their increased dependence around the middle; and, moving through their loss of individuality and affect, to the right of the line where they may be objectified by the system, and then depersonalised and be at risk of abuse.

Fig 7.2 service users and dependency



Service users in the District Team, although dependent, were mainly able to engage the social workers in a joint project of maintaining or improving their daily lives. I locate them at the left of the axis. Current policies for social workers to empower service users support this group well. The social workers in the Hospital Team worked with those who were often isolated, with no family, memory or social skills to express their individuality (such as Mr M discussed in the MDT meeting on p101). I would therefore

locate them on the right of the 'dependence' point on the axis. The danger for such vulnerable service users is that they may become objectified and then depersonalised within the care system. It then becomes disconcertingly easy to treat them with lack of individuality and respect, leading to inappropriate treatment or possibly abuse.

Total institutions appear to have difficulty in hearing the warning bells, such as 'the potential sadistic abuse of the power that staff have over patients' noted by Dartington (1994 p103). I heard these in relation to Terry's grand design for moving patients through the system and in a case discussion at the team meeting about a resident who was being denied appropriate help with toileting.

Hospital social workers are in the front line to prevent adult abuse of highly dependent people. Is there any way that routine social work intervention could reduce that risk in these vulnerable adults? From my observations and counter-transference experience in the hospital, one approach would be to minimise the tendency to objectify elderly people. A first step would be to engage with the users, rather than succumb to the conveyor belt of care. Those with the faculties to appreciate their predicament would then be enabled to reach some understanding of the drastic moves which they are being required to make.

Borderline personalities

The recognised clinical syndromes of borderline personalities in the USA are 'impulsiveness, unstable but intense relationships, identity disturbances, affective instability, inappropriate and intense anger, frantic efforts to avoid abandonment, suicidal threats, a feeling of emptiness and boredom' (Fonargy 1991). These are recognisable behaviours of many service users. They featured in the workload of all three teams. The Mental Health Team was structured to provide such people with effective help. However, service users with borderline personalities either through upbringing or later brain damage were also prevalent in the District Team – forming all their difficult case examples in the interviews. Indeed several were part of confused and complex families, known to the department for decades.

Ferguson (2005) recommended that social workers should develop skills in working with non-compliant service users. Similarly consideration needs to be given to teaching

social workers the most appropriate way of containing and helping people with border line personalities. Mattinson and Sinclair (1979), for instance, list 'good enough' ways the social worker could engage positively with a 'borderline' service user (p244)

They need the social worker to be a specific figure

Who will become familiar

With whom they can form a relationship within which emotional issues can be raised

Who is reliable and trustworthy

Who can survive and acknowledge anger and failure on his part and that of his client

Who is good enough, not totally bad nor trying to be totally good

Who can encourage the client's own efforts

Who can share and co-operate

Who can leave in a way that is not too traumatic

Winnicott (1965 p229) provides a similar list for social workers with the mentally ill on their case loads, such as

'you become reliable for the limited field of your professional responsibility; you concern yourself with your client's problem; you tolerate your client's illogicality, unreliability, suspicion, muddle, meanness etc and recognise all these unpleasantnesses as symptoms of distress'.

His remark that

'the more psychotic or insane disorders are formed in relation to failures in environmental provision, and they can be treated, sometimes successfully, by new environmental provision' (p228).

is surprisingly close to the Mental Health Team's operating brief.

Both writers help the social worker recognise the importance of providing a relationship – but also the importance of maintaining a boundary against the endless demands of the service user by being clear about the social worker's responsibility and that of the individual. The introduction of care management in the 1990s brought about a diminution of the perceived relevance of the social work relationship. Cases are 'closed' after the first review, and departments attempt to avoid long term supportive commitments. However, the District Team successfully managed to provide a core of service users with 'good enough' longer term help.

Mishan (2005) however, provides a warning note and emphasises the disturbing power of projections when attempting to work with this group. Understandably, social workers working with such people need reassurance that they are doing a good job and maintaining the necessary boundaries. I remember a psychoanalyst accepted a young

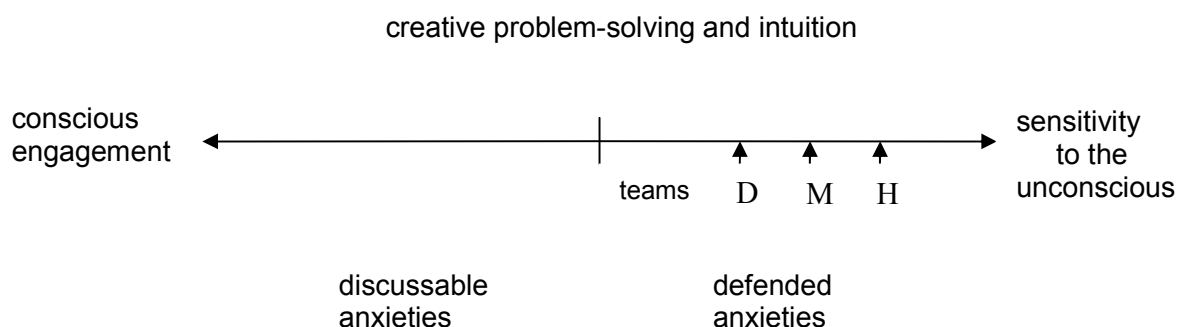
woman into her hostel only on condition that I saw her weekly. In order to maintain the sessions I needed the analyst's support to tolerate the feelings of uselessness projected from my young client and to be reassured that the sessions were helping.

Society's ambivalence to dependency and long-term needs undermines the provision of on-going support. Regrettably employers tend to imagine that tax payers expect throughput and cure rather than support and marginal improvements. The Government's initiative to tackle the socially excluded: 'Reaching out – think families' (Great Britain 2007) is welcome. But without adequate support, social workers find it difficult to maintain the ability to withstand the 'emotional and intellectual pain' projected into them by these 'hard-to-reach' borderline service users. These service users often gain the attention of the local press and councillors to assist them in their 'fight' against the 'authorities'.

Developing sensitivity to unconscious processes

For social workers to tolerate the emotional complexity of the work, they need to have insight and understanding. With an interest in the deeper meaning often contained in mundane and routine actions, a social worker accesses a source of continuing learning about human nature. It can be helpful to represent the relationship base of social work as a fabric made from a warp of internal relationships of intellectual and emotional meaning, and a weft of external relationships that provide practical support and empowerment.

Fig 7.3 social workers and the unconscious



The axis in Fig 7.3 represents the social worker's conscious and unconscious awareness – a dynamic flow that can vary from second to second. Perhaps the double helix of DNA would be a more appropriate representation of the entwined nature of conscious and unconscious reactions. The unconscious does not lie beneath or above the conscious matters of life but rather as Ogden (1997) says

‘The unconscious is not “subconscious”; it is an aspect of the indivisible totality of consciousness. Similarly, meaning (including unconscious meaning) is *in* the language being used, not under it or behind it’ (p215).

I have put at the far left of the axis, the concept of full conscious engagement, and on the right the degree of sensitivity to the unconscious. Below the line I have put the anxieties, the discussable worries on the left, and the defended anxieties on the right. These, like the District Team's fear of drowning, remain unspoken (and unsymbolised) without external help, their ‘unthought known’ (Bollas 1987). Above the line I have noted intuition and creative problem solving.

While I could not have direct access to the inner worlds of the social workers interviewed, I had not built up the customary, and necessary, defences against the anxieties absorbing the teams. This allowed me to have a variety of insights, alarms, and feelings - counter-transference - over the three placements that I use as illustrations of glimpses into the unconscious of the teams. At such times, I was positioned on the right hand side, dipping into the group unconscious. I found this an uncomfortable experience. It is not surprising that policy makers are slow to recognise this world, and that social workers do not emphasise it.

When a social worker in the District Team (D in Fig 7.3) referred to a shocking murder which had taken place years earlier near where I live, I recognised the potential hostility in the remark. I felt it was deserved, having held some ungenerous thoughts about this person's practice. But I thought it also linked to the ‘repressed negative aspect of the work which might bubble up, like effluent from a sewer’ (p88) which was a major part of D Team's hidden world. When a second murder on someone's caseload was mentioned a few minutes later, I was convinced of this.

In the case of the Mental Health Team (M in Fig 7.3) my dips into the group unconscious were confined to acute and intense discomfort when waiting for a meeting and when observing a meeting in progress. This may have been because their pattern

of joint consultation and discussion contained much of the group's unconscious anxiety. However, sight of my forgotten notebook triggered fear and paranoia (p133), showing how close these feelings were to the surface. On another occasion their discussion of a violent and unpredictable client prompted an unpleasant reverie relating to fears of damaging people that I loved.

I have marked my experience of death, despair and 'falling apart' in the hospital (H in Fig 7.3) described in Chapter 5. I found that each of the three teams shielded society from unacceptable aspects of life hidden in the unconscious, such as sudden physical or mental disintegration and death. The valuable function that social work teams form in absorbing these frightening projections needs to be adequately recognised.

As an example of instinctive and intuitive behaviour, Jill, in her work with an agoraphobic service user (see p172) demonstrated an instinctive sympathy with the person's predicament. My deftness in working with children in transition, beyond what was taught or learnt, was probably the result of my early experiences of many moves. Certainly the workshop I devised for residential child care workers on 'saying goodbye' came from the heart as well as the head.

The service users

Each team worked with slightly different groups of vulnerable adults. Each had varied characteristics and colouring from the unconscious – its 'unthought known' (Bollas 1987). For instance, most of the District Team's work was focussed on 'empowerment', the public agenda of social work with its offer of hope, 'transformation' and 'personalisation' for the service user. There is a sense of practical and emotional betterment - an easing of hostile landscapes. In this relationship, a service user's necessary dependence provoked by troublesome life events or ill health meets an empathetic response from the social worker and from society. The social worker supplies the necessary ego support for the service user to bring about change.

Those vulnerable people who need physical care, often permanently, were evident in the Hospital Team, and to a lesser extent the District Team. I use the term 'maintenance' to loosely describe the care they were expected to receive - a categorisation influenced by Miller and Gwynne's (1972) seminal study of dependence

in residential care. The social workers in the Hospital Team worked for the total institution of the hospital. The requirements of the legislation meant the social workers were not expected to take an independent approach to assessment. They were occasionally put under pressure in relation to standards expected of the social work profession. When involved in maintenance there is a major responsibility to help these vulnerable service users to maintain or regain the individuality that is easily lost in an institutional environment.

The third intervention, I call 'containment', when the behaviour of service users extends from the erratic and demanding, which was fairly common in the District Team, to acute or chronic mental distress and psychosis covered by the Mental Health Team. The term may imply more passivity than is meant - helping distressed and difficult people to sustain relationships with those who can affect their circumstances is a demanding and active process. These service users need longer timescales of supportive intervention to effect any change in their approach to dealing with life's problems. The social worker requires support to maintain that dual approach (of tolerating emotional pain while maintaining measured thought) that is necessary for a consistent and supportive presence while remaining aware of the dangers and risks.

The challenge of attending to the 'unthought known' (Bollas 1987) – those experiences both personal and professional that remain outside one's attention – underlies all relationship based work. However in social work, exploitation and abuse is never far from vulnerability, nor risk from someone 'out of their mind' with mental distress. The dilemma is how best to support social workers and others in the field (police, health workers, teachers) to have the inner confidence to see and to acknowledge and to think the unthinkable.

From the theories of the development of thinking examined in chapter 2, social workers clearly need to contain and continuously decontaminate all the beta elements and projections absorbed from their clients. This requires an ability to understand and transform these frightening primitive fears into something that can be thought about (Bion 1967). As indicated by Bion, it is likely that without this opportunity to transform and purge the beta elements from the unconscious, the social worker's psyche will gradually become choked, leading to illness, burn-out, and even breakdown. Then the

duality of their professional approach fails i.e. containing emotions while maintaining cognitive functioning.

For example, a social worker described a frightening incident

'The client was shouting "Evil bastard!" at the top of his voice as he chased me down the corridor. It was such a scary incident - I was running to save my skin!'

The social worker had anticipated trouble and asked for a colleague to accompany her. But the manager had been unable to spare anyone from duty. A subsequent failure to acknowledge the horror of the incident and provide appropriate support had left the social worker bitterly resentful and physically unwell.

It is unsurprising that social workers who lack support may unwittingly turn a blind eye to intolerable situations. Schneider (2005 p826) holds that 'not knowing can be a means of safeguarding one's very existence' if one can find no safety in the mind of another. If damaging acts against vulnerable children or adults are to be anticipated, providers of social care need to be alert to the possibility of this psychic safety-valve - 'turning a blind eye' - which unconsciously operates when the mind reaches overload. Instead of blaming their staff, employers need to clear away the surrounding impediments to creative thinking. Bostok (2004) appositely quotes a service manager saying

'we don't want more guidance, procedures, or memos saying "Why aren't you doing things?" Instead we need some time for reflection, time to chew things over' (p43).

Factors that impede or support creative problem solving

Reflection on what I saw and heard in the three teams led me to examine five enabling factors which are crucial for effectively delivering the contract that society currently requires of social work. Two appear tangible and measurable factors (policy coherence, support services) - whereas three appear more intangible: the quality of professional development, autonomy and mental space. But just as my observations recorded the visible practical elements of the day while the reflective commentary added the other half of the tale, so 'surface' external issues such as the policy framework are deeply intertwined with 'depth' internal issues such as society's need to hide emotional pain

which then has to be addressed by social workers. To do this social workers need appropriate mental space.

Coherent policies

The evidence from the teams supports Hoggett (2000, 2006), Cooper and Lousada (2005) and Chapman (2004) who contend that poorly defined legislation demands a disproportionate amount of staff time to unravel its meaning. I was struck by the amount of time that D Team spent discussing 'no recourse' cases, as there was no interpretation of the legislation available. Similarly H Team had to discuss the confusion in the Continuing Care legislation. I analysed the policies with which the teams had to work and categorised them according to usage (high, medium or low) and to confusion (also high, medium or low), see Fig 7.4. I investigated the impact on staff of the complaints procedures and concerns over adult protection. This led to a further category on the impact of policy on the team eg The Community Care (Delayed Discharges) Act 2003 had caused little confusion for H Team, but had a high impact on their work.

Fig 7.4 High Confusion and High Impact policies

Policy	District Team	Hospital Team	Mental Health Team
NHS and Community Care Act 1990	HU LC	HU LC	nil
No Recourse to Public Funds	HU HC	nil	MU HC
Community Care (Delayed Discharges) Act 2003:	nil	HU LC HI	nil
Continuing Care	HU HC	HU HC	nil
Direct payments	HU LC	nil	nil
Adult Protection procedures	HU MC HI	MU MC HI	nil
Fair Access to Care Services (eligibility)	HU LC	HU LC	nil
Adult complaints procedures	HU MC HI	nil	Nil
Rough Sleepers Initiative	nil	nil	HU LC
Mental Health (Amendment) Act 1983	nil	nil	HU LC

HU High use **HC** High confusion **HI** High Impact

MU Medium use MC Medium confusion

LU Low Use LC Low confusion

Nil = researcher not aware of use of this legislation in the team

As can be seen in Fig 7.4, the District Team had two 'high confusion' policies to manage: no recourse, and continuing care; and two high impact procedures: complaints and adult protection. The Hospital Team had to deal with continuing care and adult protection. It was dominated by the high impact Delayed Discharges legislation. The emotional content of the work had to be ignored leading to unintended consequences - the whole management team left. The Mental Health Team had less demand from no recourse cases and remained comparatively unaffected.

Direct Payments was an example of a policy which had now settled down. It was designed to empower people with disabilities to purchase their own help. As with most bureaucratic developments in the first decade of the 21st century, this put the organisational task wholly on to the service user. Frequently they and their immediate carers were too preoccupied by day-to-day problems to take on the additional demands of contracting and financing their own care.

Direct payments also created conflict and dilemmas within the care management process. The sense of social justice and fairness that social workers bring to the work was affronted when service users attempted to exploit the system

'When I saw her she was lying in bed. She said she couldn't walk and was buying in all her services. Then the OT saw her getting on the bus. I asked her and she denied it. It's very difficult to say who are the genuine cases' (Int 9D).

Unsurprisingly, social workers became more wary of accepting people's tales. To ensure government targets for take-up were met, the appointment of a specialist Direct Payments Officer was required who designed a robust assessment system and enrolled a supportive specialist charity in order to help the service users to manage the finances.

No recourse cases

In 2005 The District Team were faced with financial uncertainty arising from the recent need to ascertain the status of destitute people who had no recourse to public funds. I had been surprised to discover the amount of work about which there was little information and no debate. 'No recourse' seemed a demoralising purgatory between the heaven of legal asylum or residence and the hell of a forced return to the country of

origin. Those with no recourse included refused asylum seekers, people on sponsorship visas where the relationship with the sponsor had broken down, people who had overstayed their visa - as well as people who originally arrived in the UK on a visa and subsequently put in further representation to remain in the country (NRPF Network 2008).

The council was permitted to provide destitute people with temporary accommodation until fit enough to be deported - if categorised as having 'an assessed community care need as a result of ill health disability or age, an assessed mental health need, pregnant women and nursing mothers, or adults with responsibility for children' (NRPF Network 2008). This interface between immigration, community care and human rights law had proved a fertile area for less scrupulous solicitors to obtain resources for their clients.

'The very difficult cases are people seeking asylum. We started to get some pregnant women – it almost seemed like some sort of scam. They all seem to come from the very same part of the world and we got half a dozen in a couple of weeks' (Int 6D)

The council could either comply with the solicitors' demands or take the case to judicial review, which was an established way of developing case law. But the council's legal department had limited resources and were not prepared to risk the uncertainties of judicial review, which typically cost £30,000 per case. It was cheaper to concede the applicant's right to services. The in-house lawyers therefore tended to recommend the acceptance of the arguments presented. It took the social workers and housing officers months to convince their lawyers that they should take the risk and confront the clients' solicitors to avoid an increased amount of expenditure on these cases. Mrs H's situation (p74) was one example of a dozen current cases.

However the office staff were also repelled at the stigmatising aspects of the policy that they were expected to implement

'But it can be quite distressing. Although they get a bad press, they don't get a lot of help – not as much as people on benefits. We had a case recently where a woman was given vouchers and these were refused at Tesco's. They wouldn't let her buy sanitary towels with them. So she had no money or nothing and it was clearly very humiliating' (Int 6D).

The interviewee was the third person to recount this incident to me. They were all shocked by the lack of humanity demonstrated by the supermarket check out staff.

The Hospital Team was not affected by the no recourse process, although the uncertain legal status of one or two patients was beginning to cause concern. But when I was with the Mental Health Team a year later, they had begun to come across 'no recourse' cases amongst homeless service users. The criteria for providing services was whether or not the service user was suffering from a psychotic illness or possibly post traumatic stress disorder (PTSD). From the point of view of the staff, surviving rape or imprisonment or severe injury in one of the dangerous civil wars around the world was sufficient proof of the service user's need for help, if not for medical intervention. As the numbers increased the PTSD diagnosis was likely to be challenged by the mental health trust. One social worker found that a client was not entitled to free health care or services

'which doesn't kind of make sense to me at all. It is very difficult. You want to help her and do something. But really you can't do anything. I do feel it is a very discriminatory system. We are stigmatising them by giving them vouchers which identify them as asylum seekers. It is really unpleasant and they quite often feel persecuted. The whole thing is very unpleasant. You kind of think 'well what can I do? (Int 11M)'

Again, the repressive nature of the legislation was in conflict with her professional values.

Social workers had to manage the uncertainty of these legal arguments alongside the uncertainty of their service users' circumstances. For instance, D Team had become involved in a case with the education department. Some years before a woman and her two children with no recourse to public funds had been provided with accommodation paid for by the children and young people team. There was now a question that she had 'borrowed' the two children to qualify, as they were not attending the schools she had named. She might also be sub-letting the accommodation. Child trafficking had been mentioned

'It's very difficult when doubts have been sown in your mind. But somehow my mind tells me that the girl that I saw at the hospital is very different to the girl that I saw at the house. This is a horrible case. We are trying to get the police and child protection fully involved. It's very complicated. I definitely don't want too many cases like this' (Int 8D).

One mother from the West Indies had joined her mother resident in England. She was in her forties, employed and earning enough to keep herself and her children. She

suddenly had a severe stroke which left her immobilised and destitute as she had had no work permit. The social worker found that:

‘She and the two children and her mother were living on mum’s benefit which was a pittance. The GP and I visited as she wasn’t taking her medication. It was really sad. Where the children are concerned it really gets to me. I brought her some stuff down but there is so little you can do because it’s no recourse’ (Int 9D).

This social worker felt as helpless as the stricken service user, unable to fight against what she experienced as an arbitrary law.

Delayed Discharges

The Delayed Discharges legislation appeared well-matched to its policy objective of freeing up acute beds in NHS hospitals. However, it had some unintended consequences. Firstly, if patients were discharged prematurely and readmitted hours or days later, they were counted as ‘new’ cases with a substantial cost to the Primary Care Trust’s budget and the commissioned work. Hence the savings were less than calculated.

Secondly patients were objectified as the social workers avoided recognition of the pain and loss involved for their clients. They did not have the space to empathise with the client’s predicament and provide support when considering their situation. The emotions provoked by the need to enter residential care – sadness? relief? - may have been an integral part of the service user’s personality at that moment. Their feelings needed to be acknowledged in order to be related to fully. But the pressure of hospital targets meant that the manager told new staff

‘Forget about hand-holding, it’s a conveyor belt here!’ (Int 5H)

Perhaps this was an underlying purpose of the timescales – they were a defensive manoeuvre to allow society to care for or to ‘maintain’ dependent older people without incurring the pain of emotional engagement.

Thirdly, the two-day discharge timescale allowed no time to process the emotional impact of the work on the staff. While the social workers managed this through avoidance, the managers appeared to attract and collect the undigested elements of the work. These are possibly the unprocessed projected unconscious feelings, or beta

elements (Bion 1962) – which, I suggest, lead to illness and burn out if not dealt with. While staffing levels in organisations are inclined to ebb and flow, the rapid loss over four months - the service manager to chronic ill-health, the operations manager to a dispute about leave and the team leader to redeployment after a restructuring exercise - were exacerbated by a lack of mental space and support.

Continuing Care

There have been demarcation issues between health services and social care services in the community in the past - the disputes over who paid for the bathing service were legendary. But the stakes for the vulnerable individual in the argument on Continuing Care funding were uncomfortably high. The Government rejected in 2001 the recommendation of the Royal Commission on Long Term Care (1999) for free personal care according to need (Dartington unpublished 2007). Thus care provided by local councils was means tested, but not the NHS continuing care provision.

NHS trusts and local councils developed criteria for a banding system. This set out Band One: needing total nursing care, Band Two: some nursing care and some personal care and living costs, Band Three: entirely social care (personal care and living costs). Naturally patients with chronic illnesses assessed at Band Two wanted another opinion before their limited personal savings were absorbed by the decision. However, following a report by the Health Service Ombudsman (2003) some care home residents were retrospectively awarded free NHS continuing care within the care home.

In Visit 10H I met the storm caused by the Grogan judgement (Chapter 5). Mr Justice Charles had said in the conclusion of his judgement published a couple of weeks earlier (Grogan v Bexley 2006 paragraphs 106, 107) that

‘this question should be remitted to the Care Trust for fresh and further consideration. The Care Trust should:

- i) identify the test it applies.
- ii) in doing so address the point flowing from s49 HSCA 2001, and the sequential argument advanced by the S/S and adopted by the Care Trust, that the Coughlan test on what the local authority could lawfully have done addresses the issue prior to the prohibition introduced by s 49 HSCA 2001, with the consequence that at the first stage of the sequential approach it is relevant to consider whether all the nursing needs in the accommodation

(including the RNCC) could have been lawfully provided by the local authority prior to the enactment of s 49 HSCA 2001'..... etc

This brief extract of a thirty three page judgement gives insight into the detailed attention required from each local authority to understand the implications of such statements. It was another month before the Department of Health issued guidance notes on its meaning. Unsurprisingly, the minds of the senior managers were filled with uncertainty on the 'right' decision at the cost of other concerns. The principal officer explained that the only policy officer employed in the Department worked full time on issues relating to the Department of Health's Performance Assessment Framework. Hence there was no capacity to advise senior management on the ruling. No wonder she spoke of 'a crisis in capacity' and the need for 'more desk work from social workers' (Int 6H) in case that allowed more mental space.

Professional development

A second area that appeared to impact on social workers' ability to approach problem solving creatively was their attitude to professional development and that of their employers. I found all three teams contained highly motivated people with considerable professional skill in making judgements and in working with damaged and irrational people. Their feisty determination and enthusiasm reduced the impact on the researcher of the smaller number who felt undermined, burnt out, or had become detached from the group endeavour. I looked at each staff group from several angles – the proportion of engaged staff; who had chosen to work with this team; who were committed to further post qualifying training; who had other development opportunities; who could work in pairs and who held social work values (see Fig 7.6).

Proportion of engaged staff

As can be seen from the table each team had some staff who, for a variety of reasons, appeared to be detached from the group endeavour. The hospital had the widest range of disengaged staff, while the mental health team had the fewest. The District Team had begun to tackle a problem of long-standing sickness which resulted in one member of staff leaving during my placement.

Chose to work with client group / team

The District Team staff had a strong identification with their service user group

'Younger adults are in tune with what is happening around them. They may be disabled but they are very alert mentally. You have to be very clued up with the information you have as they are constantly challenging what you are talking about' (Int 11D).

Three social workers had left unsatisfactory posts specifically to join D Team

'So the next day I handed in my notice. I had a huge mortgage and two children and thought 'Damn, what have I done?' Then I had an interview here and joined straight away. The good news is that I have more autonomy here and can get on with my job' (Int 11D).

'I moved to X which was nearer home but I couldn't deal with the systems and the management style – I don't need anyone threatening disciplinary charges if I advocate on the client's behalf. So I handed in my notice without anywhere to go. I came back here temporarily as I was desperate to be with people who could appreciate me and see what I could bring' (Int 4D).

Fig 7.5 professional development

Italic script = difficulty plain script = supportive

Evidence	D Team	H Team	M Team
No. of staff	21 (3 managers, 14 soc workers 1 specialist worker 3 admin)	22 (4 managers, 12 social workers, 2 specialist workers, 4 admin)	18 2 job-share managers, 1f/t psych 1p/t SHO 1p/t cons psych, 2 f/t ,4 p/t, CPN 3 f/t swkers, 1 f/t OT, 3 admin
Empowered /	1 mgr 6 swokers 2 admin (4 swokers, 1 admin 1 spec worker on way)	6 swokers, 2 spec workers 2 admin (4 swkers unknown)	16 (1p/t psych unknown)
<i>Undermined, burnt out or detached</i>	<i>2 mgrs 4 swokers</i>	<i>4 mgrs, 2 swkers 2 hosp admin</i>	<i>1 p/t mh worker</i>
Chose to work with client group/team	9 Yes	10 Yes	16 yes
Post Qualifying training	Yes, if you fought for it managers could only do one at a time	Yes, if you fought for it and were prepared to do without support	Yes, normal part of career eg all 4 swkers were ASWs
Development opportunities at wk	<i>Limited</i>	<i>none</i>	Yes – for everyone
Working in pairs	<i>Rarely – for 'flagged' cases only</i>	<i>Never</i>	Often –outreach visits, assessments etc
Social work Values	yes	yes	Yes

In the Hospital Team everyone interviewed had chosen to work there

‘I’d never worked in a hospital before and I found I was enjoying it. I tended to work quite quickly. I liked to be busy and this environment gave me that’ (Int 3H).

The Mental Health Team had an excellent reputation and all staff had made a positive choice to work there

‘Its different, it’s interesting and challenging and working with people who are very marginalised and traumatised’ (Int 3M).

Commitment to post qualifying training

It was impressive to learn how determined some staff were to continue their further education. For instance in the District Team

‘I had a wealth of experience prior to being qualified. I came in mature and had a plan. I had a developmental programme I wanted to do. My target was to do my PQ One training and then to get straight on to become an ASW. I processed all the bits and sent them to the University...I did it within the timescale ...you must have a vision of where you are going or you can become pushed around professionally and in relationships with individuals’ (Int 11D).

In the Hospital Team

‘I’m academically minded and I get on with it. I was one of the first people here to get PQ1. They don’t support PQ2 but I have gone ahead and am already on the last leg of the qualification with a local university’ (Int 4H).

The consultant psychiatrist in M Team had set up a Master’s level degree course at the nearby university. This created a strong ethos of personal development, helped by the group’s ability to manage flexible employment patterns. A large proportion of the staff had postgraduate qualifications, which added to the richness of debate and creativity in the group. In contrast, despite the determination of some staff in D and H Team, there were only sufficient supervisory or financial resources for one or two people to undertake the PQ awards at any one time. Other social workers, however, saw retirement rather than continuous professional development as their next ambition.

Development opportunities

It was surprising to observe the limited approach to staff development in both the District and the Hospital Team. This may have been an illustration of the senior

management team's anxieties and preoccupations around their work. The financial constraints showed in the indifferent accommodation, lack of financial delegation and lack of replacement managers. This led to an evident lack of mental space for everyone (see next section) exacerbated by rigid procedures introduced to curb spending. It was not an environment to encourage the bright young administrator to develop a programme to monitor referrals, nor for the manager to present the team's work to representatives of the Department of Health (p89). In contrast, the Mental Health Team used their staff imaginatively. The Information Officer produced management statistics of a standard to impress their commissioners. She also kept all the forms and procedures up to date and developed a presentation to explain the team's role to other agencies.

The Hospital Team appeared totally preoccupied with the burdensome process of effecting timely discharges. By turning down the Operations Manager's application for unpaid leave (p112) was overtly perfectly rational. But the council gave a covert message that the personal initiative he had taken in setting up comprehensive systems to manage the discharges was not to be recognised or rewarded. The Mental Health Team had a different approach. They were flexible in employment procedures, having several former CPNs back on a part time basis to cover duty. They also expected each member of staff to take on distinct community responsibilities - e.g. to liaise with a hostel and day centre, to be an advocate for the team and its service users, to provide training for other mental health professionals and volunteers. Being multi-disciplinary also meant that each individual professional could be called on to be the 'expert' for assessments etc. The single manager post also allowed more delegation of responsibility and avoided the need for an additional management tier.

Working in pairs

This simple way of helping to induct or develop social workers is rarely used in community teams. The demand on resources would be seen to outweigh the possible benefits. Alerted by the liveliness of discussion in the mental health team, I discovered the strength and support the social workers found in shared working. They did all their outreach work in pairs as this involved visiting the rough sleepers early in the morning or late at night. Joint assessments, both formal and informal, also took place regularly. 'Two heads are better than one' seemed the accepted rubric. It allowed for an

openness and acceptance of skills and limitations. It provided confidence and security in work with difficult people e.g. the one time that the District Team sent a companion out with the social worker (p75 Section 13). It allowed people to observe and learn different techniques and ways of relating to people. It also provided role models in different situations, which would have been valuable in the Multidisciplinary Team Meetings in the hospital (p118).

Shared social work values

These were expressed across all three teams

'I know from my nursing career that once you leave your home you will never have a peaceful night but will be checked every hour. You will never be taken out anywhere. You will never get on a bus. I want to delay people getting to that stage' (Int 14D).

'These measures we are implementing have implications for future services. That is important to me' (Int 4H).

'It fits in with my values of social justice and helping people access services' (Int 3M).

The importance of social work values was also evident when social workers were required to undertake work counter to their professional values, as occurred in the no recourse and delayed discharges work above.

Mental space

I had the opportunity to observe, interview, and question the provision of mental space during the months of fieldwork. I have collated my findings in Figure 7.6 below, so the reader can compare the teams. It can be seen that social workers in the District Team had few opportunities to discuss their work. They valued the chance to sit near an experienced colleague, or to talk to a team leader or senior who were always approachable. These were their main occasions for developing practice. Even the frequently mentioned 'teatime talk' was mostly taken up by presentations rather than discussion.

Departmental meetings on specialist areas were supportive for those who attended but longer standing staff wanted a second 'Away Day' to discuss different internal

structures for managing the work. The space in the team meeting was largely filled by the manager. He appeared to fear that, if he stopped talking, the beta elements projected by their service users and society might crash down on them all like a tidal wave. Sometimes words, rather than symbolising and containing complex feelings, can be used defensively to avoid the space to think.

Fig 7.6 opportunities for mental space
(*Italic script: difficulty* plain script : supportive)

Type of space	District Team	Hospital Team	Mental health Team
Personal reflection	<i>Difficult with open-plan office and noise levels</i>	? probable	Yes
Spontaneous – colleagues work	<i>No, Staff did not know of each others' cases</i> Talk to neighbours	Yes	Yes
Spontaneous – colleagues social	Yes	Yes	Yes
Spontaneous - managers	Yes	Yes	Yes
Supervision	<i>Said to take place but never seen</i>	<i>Officially abandoned</i>	Yes, regular –mainly managerial advice
Allocation meetings	<i>No, team leader approached individuals</i>	<i>No, workers took all cases as required from their wards</i>	Yes – at the Monday team meeting
Case discussions	No	No	Yes – at the Thursday case discussion meeting
Learning slots	Yes, at the monthly Teatime talk	No	Yes, at the monthly learning support group
Team meetings	<i>Fortnightly. No, manager ran the agenda and dominated the space</i>	Fortnightly. Yes, space to bring a case for advice	Weekly Yes. Rotating chair, clear agenda and anyone brought an issue
Multi disciplinary team (MDT) meetings	N/a	<i>Took place on every ward every week. Social Worker alone, Original purpose lost, Daily 'bed mtg' worked</i>	Yes, all meetings MDT. everyone had different hostels to support, groups to represent the team at etc
Internal management meetings	<i>No, unclear as who should attend and usually cancelled.</i> Manager attended dept meeting with peers	<i>No, the two managers talked informally, no help from senior manager.</i> Manager attended dept meeting with peers	The job-share manager attended the CMHTs social care meetings with peers
Departmental meetings	Yes: Adult protection, young carers, no recourse etc	probably	Yes, network of organisations and hostels. Attendance shared amongst all staff.
Team away days	<i>No – only one in 3 years</i>	<i>Unknown, not recently</i>	Unknown
Consultancy	No	No	Monthly team support group, Consultant psychiatrist available twice a week
Departmental Training Days	Yes	Yes	Yes

Smaller offices helped the hospital social workers to form close relationships with their colleagues. They had to rely on each other in the maelstrom of Delayed Discharge

legislation and the collapse of the management structure. Without supervision, they were dependent on the team meeting. This was the only wider forum in which they could explore together how to develop multi-disciplinary relationships within the hospital and across the social services department. It could not, however, replace the absent manager in dealings with the hospital hierarchy over accommodation and resources.

The effects of this professional isolation were particularly conspicuous at the MDT meetings. These were not functioning as originally proposed - to pool and share multi-disciplinary approaches and information needed to optimise care or treatment for the patient. But the participants appeared unaware of this. One of the three MDT meetings I observed occupied 22 person hours. There was no discussion held or decision challenged. The views of the consultant and the Senior House Officer on the action required could have been emailed to participants. The team members would then have been able to spend the time more usefully talking to patients. There was no social work management pressure to improve the performance of MDT meetings. Two experienced social workers had challenged the consultants in charge with their failure to consult all the professional staff present. Attending alone, new staff had no opportunity to observe best practice and adopt a more robust attitude.

Lack of discussion risked social workers being put into a state where they could not think clearly about the issues and the task. The placement officer, for example, described the mental effects of the bullying and coercive culture which had built up in other hospitals over discharges

‘You cannot make a system work by cracking the whip down the line – that’s bullshit. You’re just going to get resentment. People will be sent into a panic and won’t work properly’ (Int 1H).

The Mental Health Team had structured comprehensive opportunities for using mental space. Working with a demanding and occasionally dangerous population, these spaces provided a good match between the needs of the mental health workers for reflection, creativity, problem solving, and for managing the projections from the clients, as well as satisfying the homeless person’s need to be kept in mind (see Fig 7.6 above).

Supervision

In social work it has been assumed that regular supervision sessions would be held between the social worker and their manager where such issues would be discussed and resolved. Traditionally the three ingredients of casework supervision were monitoring, support and training. But Ruch (2007) suggests that only monitoring remains. Certainly in the one team where supervision took place regularly staff considered it 'managerial' rather than 'clinical' or 'therapeutic'.

However, during the research period supervision was not active in two of the teams. Managers would meet with staff for specific reasons eg adult protection or a complaint. Owing to staff shortages, it was patchy if not temporarily defunct in the District Team. While in the Hospital Team, the two remaining managers formally replaced supervision with an 'open door' policy to cover the staffing crisis. Bostock (2004) also found whole Children and Family teams without functioning supervision. Interestingly the team which did provide regular supervision - the Mental Health Team – did not want me to observe a session. It was as if the expectations of this process had become so high that people feared scrutiny and criticism or even holding a session. I wondered if there was any regular training and developmental support available for those who had to provide staff support and clinical supervision. I knew of none in previous decades.

Autonomy

Central government curtailed local authority autonomy when the Conservative Government moved from local to central taxation under Treasury control in the mid 1980s. Funds were then allocated to Councils only when their service plans met Government criteria. There was some room for senior management to delegate power and responsibility to the front line. Balloch et al (1995) found that high morale for front line workers depended on their ability to make decisions, and some authorities tried to encourage this. It allows for professional effectiveness and encourages staff to maintain an 'adult' and equal relationship with managers.

However in the succeeding decade, Governments became more prescriptive in many public sector professional areas. Social workers failed to influence the development of performance indicators at the introduction of care management in the early 1990s

which were then left to the accountants. Hence social workers appear to be doomed to 'value only what is measurable rather than measuring what we value' Wheeler (1999 p146). In social services departments, a proposal for new services would not count towards the Performance Assessment Framework unless it was listed. Departments could not afford to implement new locally generated ideas. Constant financial crises increased senior management involvement with front-line activities. Examples include the senior management team's decision to take over the salaries budget of the District Team, to refuse maternity cover, and to require every assessment of care services to be agreed by a panel. This impacted on morale.

'I may have to make a professional judgement about seeking a placement for someone in an adult protection situation but I am not empowered to decide to provide someone with meals on wheels without discussing it with a manager or going through a funding panel. This takes away our confidence in making decisions, and that in turn interferes with the way we think' (Int 17D).

Staff seemed inhibited from mounting any challenge due perhaps to the projections from their helpless clients.

This antipathy to micro-management is more understandable when Winnicott's (1971) observations on creativity are considered. He uses the word 'creativity' to refer to 'a colouring of the whole attitude to external reality' and specifically contrasts creativity to compliance

'It is creative apperception more than anything else that makes the individual feel that life is worth living. Contrasted with this is a relationship to external reality which is one of compliance, the world and its details being recognised but only as something to be fitted in with or demanding adaptation' (p76).

In addition, when managers can restrict or monitor the flow of work to the type and quantity that the team can manage, the team feels empowered (Rice 1969).

The Mental Health Team, who were able to turn away anyone who was not both mentally ill and homeless, felt that. The District Team in contrast dreaded becoming 'the anything else team' (Visit 1D). Consequently they had both an administrator acting as 'duty screener' on the telephones and a team leader checking all referrals in order to protect their boundary. Time spent protecting the system – 40% of each team leader's week – may have been essential for workflow management but was not then available for other management activities like meetings or staff supervision.

However, D Team did operate with more individual autonomy and discretion than they seemed to recognise. On one hand I was told

‘In other teams social workers have more freedom to make decisions. But here everything goes to panel. The manager makes all the decisions. That means one’s expertise is not fully utilised. In some cases we should have more freedom – I’m made to feel so dependent’ (Int 2D).

But in their reassessment of Lipsky’s study of ‘street-level’ bureaucracy’ (1980), Evans and Harris (2004) find evidence that social work discretion can operate in situations where there is little other autonomy. This was illustrated by the District Team’s ability to negotiate imaginatively with their clients despite financial constraints. For example, Marlene’s tale at the start of Chapter 3 shows how she helped a brain damaged man to recover his life, when he could easily have been left to be imprisoned.

There were other examples, as when Jill successfully argued this exception to the eligibility criteria

‘I bumped into Sue out shopping with her carer last week. I said ‘Hello’ and she said she went shopping once a week now. That’s superb – she had not stepped out of her house at all for four years. She was in a terrible situation physically. I tried everything. Then I got her to wear socks and parked right outside the shop so she could get some shoes. That’s what I did. It was the only way I could think of to get her out’ (Int 3D).

Of the three teams, the Hospital Team had the least autonomy and discretion over their work. Not only did the team have to take on every person who genuinely needed discharge (the social workers challenged those whom they thought too ill to consider moving), but it also had to respond to hospital reorganisations. For instance, hospital discharge co-ordinators were superseded by modern matrons. The social work department suddenly had a new cohort of health service colleagues with whom to work in partnership and to educate into the complexities of the Delayed Discharges legislation.

The timescales demanded by the legislation to assess home circumstances, interview relatives and produce a report for panel within two days, could ‘bunch’ to produce considerable pressure. As a non-social worker said of outlying hospitals

‘It’s a hierarchy in the hospital. The consultants shout that they want acute beds. Nurses panic. Doctors panic. They don’t fill out an assessment properly. They don’t understand the procedure. They don’t understand that to arrange a

discharge, a social worker has to physically go to the hospital, assess the patient and then come back and do a load of stupid paperwork' (Int 1H).

This preoccupation over discharges was clearly questionable since no one in the hospital collected statistics on premature discharges which resulted in readmissions, though known to be frequent. A cost-benefit analysis needed to be done.

Performance management systems were being introduced in the District and Hospital Teams. These could help to clarify the social work task and allow for more autonomy. Senior social workers, for example, were unclear about the management aspects of their posts. Social workers were equally unsure if they should help service users with the emotional aspects of their physical predicaments, such as mourning the loss of their home to make a better adjustment to residential care. However, frequent transfer of budgets over the head of the manager to other divisions or departments undermined discussions on the advantages of autonomy for staff performance as well as morale and creativity.

The Mental Health Team seemed to avoid this interference. Admittedly I was there in the summer months when there was less threat of elderly homeless people dying of hypothermia, and the consequent media embarrassment. The team appeared to work throughout with considerable professional confidence and autonomy. It appeared to have a functioning performance management system. For example the manager and occupational therapist shared the work plan which they had agreed at her annual review with the team.

As one of M Team's social workers explained

'The work is very varied. It's not just about cases – we get involved with training too. It's a democratic team and we have a relatively equal say in what goes on. We all feel that we have an input. So I think that these things make it an interesting team to work in. I can't see myself in a team with a consultant psychiatrist in the lead, where I was just instructed what to do. It wouldn't really work' (Int 3M).

In this extract, the social worker expresses her professional confidence brought about through development in a variety of roles. She contrasts it with a dread of working without a sense of autonomy in a hierarchy.

Support structures

Munro (2002) points out the employer's obligation to provide an effective working environment, the lack of which was so brutally exposed in the Victoria Climbié enquiry

'The quality of the physical environment affects people's ability to function. It is harder for people to concentrate in noisy, crowded, unheated or badly ventilated offices. Adequate administration and IT support are also important factors in enabling staff to concentrate on the difficult aspects of their work' (p142).

However she does not highlight the support that good management practices can provide for a team. During the fieldwork I was conscious of the variety of pressures under which the teams worked. Figure 7.7 tabulates these and provides the reader with a comparison between the teams.

Fig 7.7 available support structures

	<i>Italic script = difficulty</i>		plain script = supportive
Activity	D Team	H Team	M Team
Management practice	<i>Unpredictable, no longer term planning</i>	<i>Had been excellent, now collapsed</i>	exemplary
Admin	Yes	<i>No - uncooperative hospital employees</i>	yes
Information	<i>No, always changing</i>	<i>No- rely on colleagues</i>	yes
IT	Yes, in part	<i>No help because LA system</i>	yes
Finance	Some resources, <i>needed quiet.</i>	<i>None-done by social workers</i>	yes
Use of staff	<i>Conservative</i> Specialist direct payments officer	<i>Never challenged hosp on admin</i> extra specialists for delayed discharges	imaginative
Statistics	<i>No – manager did not delegate</i>	Yes, specialist staff	Yes Info officer
Resources – time, people, money	<i>lost budget to C&F no manager /senior</i> Yes, able to appt locums	Hard pressed	Yes - able to meet demand
Office environment	<i>Overcrowded and noisy</i>	<i>Fragmented</i> but quiet	Adequate

The Hospital team had the least effective support structures. The management team had collapsed - with the final resignations on the day that I left. While support and advice was available on a demand basis, there was no management capacity to step back and view the work with a sense of perspective. Their successful management of delayed discharges appeared merely to encourage the hospital administration to attempt to sequester more local authority resources – eg wanting the team's 'step-down' beds for other patients. There was also no management capacity to challenge the hospital on the working standards of its administrators.

Team members spend hours copy-typing assessment forms - which may have served a defensive purpose - rather than being trained to use the tablet computers which had been purchased. They queued to send faxes from one machine to the wards, rather than challenge the unco-operative administrators to do this. They had no business support to complete the IT procedures of invoicing for all the services set up. These disruptions added considerably to the overall time pressures. However their specialist posts appointed under the Delayed Discharges Act worked extremely well eg the joint housing officer/ hospital discharge post.

The District Team staff had lost the deputy manager and a senior social worker in quick succession on maternity leave. The deputy's tasks had been reallocated, but the team leaders appeared unsupported with the additional work. Management meetings were cancelled. The remaining seniors were uncertain as to their role. While supportive specialist consultations were always held, regular supervision was lacking.

The team had the worst accommodation – an open-plan office with a bank of desks belonging to another department in their midst. One interviewee summed up the problem

'I have been listening to people on the phone telling me that their cancer has advanced or their relative had died and people have been laughing really loudly next to me. No only have I been conscious that they can hear the laughter but it has affected my ability to respond, to think through how to respond in a sensitive way' (Int 17D).

The IT system worked well as one of the administrators was skilled in sorting out problems. However staff were confused by the frequently changing instructions for the computer records system. These were an unnecessary distraction - as was the constant updating of forms. The proliferation of agencies contracted to provide home care increased the work load

'We used to have two organisers who covered the whole borough but now we have all these different agencies and you have to ring around and sell it – "I have a lovely lady for you" sort of thing. Sometimes though, not so lovely!' (Int 9D)

When the domiciliary care contract was retendered, there was anxiety on the disruptions and changes that would be set in train for service users. It was a relief when most staff were subject to TUPE arrangements and continued in post.

The job-share managers in the mental health team managed the team's relationship with its different commissioners – covering two local authorities and primary care trusts. They also oversaw relationships with the many voluntary sector providers, the police and the acute mental health facilities. Staff enjoyed the delegated support roles with all these partners. The most impressive aspect of the management practice was the handling of the Monday team and allocation meeting, and also the Thursday case discussion meeting. This was a role model given by the prompt time management, full attendance, and competent chairing skills from all staff members and thoughtful discussion. The joint learning event with the psychologists and the consultancy with the staff group also took place regularly.

The multi-disciplinary staff group were deployed flexibly, as seen in the case of the Information Officer's role. Former staff who were retraining in different professional areas were also employed a couple of days a week to fill the duty officer role. This was the only staff group who did not, in my hearing at least, complain about the IT system and demands of record keeping.

Once service users in any of the teams had met the eligibility criteria adequate resources were made available. Indeed the provision of sheltered housing and other alternative accommodation had improved considerably in recent years.

Five Enabling Factors

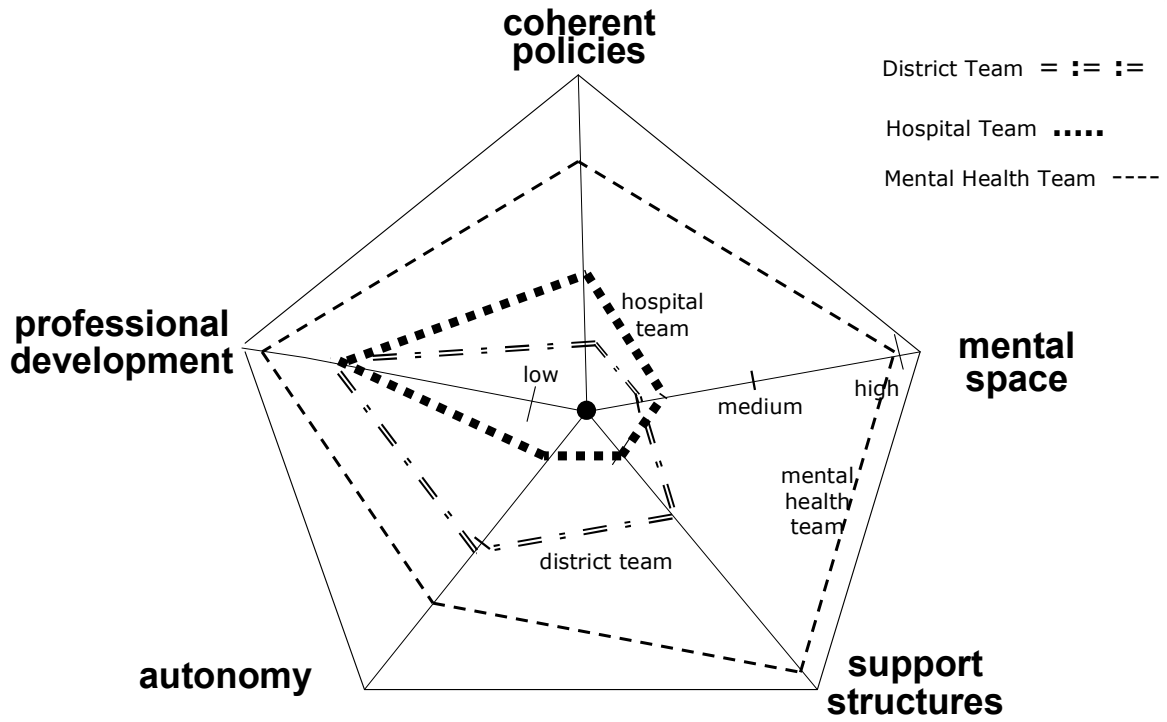


Fig 7.8 comparisons between teams

The analysis in Fig 7.8 compares the performance of the three teams against the five enabling factors identified by the research. All the teams had professionally motivated staff. The Mental Health Team maximised mental space to work creatively and consistently with a difficult and occasionally dangerous client group, having clear boundaries for accepting work and managing their own staffing budget. The team outperformed the District Team and Hospital Team in professional development, autonomy, coherent policies and support structures. Both the District Team and Hospital Team had limited opportunities to find and use mental space. This clearly affected their wider performance.

Chapter 8

Conclusions

Introduction

This study has analysed what supported or prevented creative thinking in three social work teams working with vulnerable adults. The teams respectively: supported people with disabilities in the community; arranged care for people discharged from hospital; and helped homeless mentally ill people. Many service users were at risk of abuse or lived on the margins of the local community.

The study was underpinned by a number of theoretical concepts relating to the development of thinking and creativity (Bion 1962, 1967; Winnicott 1965, 1971; Klein 1952; Britton 1989). It also considers the effects of neglect and trauma on thinking (Mattinson and Sinclair 1979, Steiner 1985, Garland 1991, Schneider 2005) and the relevance of this for social work practice (Rustin 2005, Cooper 2005, Ferguson 2005). The need to understand and broaden the concept of support for social workers was reinforced by Bostock et al (2004) and Ruch (2007).

The psychoanalytically informed observations provided insights into the unconscious preoccupations of the teams. These allowed understanding of the emotional meaning of the work for each team, the anxieties against which they were defending, and the contribution of the service users to the culture of the team. Interviews informed a meta-comparison between the teams and showed that mental space was vital to allow team members to think creatively. But other enabling factors were also essential: coherent policies, professional development, a sense of autonomy, adequate management practice and support structures.

The study found that the team which maximised opportunities for reflective thought - through case discussions, supervision and shared working - helped a challenging client group, made a business case for resources, and was sensitive to emotional undercurrents. But it found that the teams which had limited mental space - with no regular supervision, case discussions or joint working - were less able to challenge

other professionals or meet the needs of more damaged service users. The chapter explores the implications for practice for different audiences across the profession.

The research process

The three teams which agreed to the research project (Chapter 3 and Appendix 2) were comparable in size, geography and client group. They formed a multiple-case study from which valid comparisons could be drawn. I structured the research placements in two parts: the formal observations in Part One and the more participative observations alongside interviews in Part Two. The visits were spread out over six or eight weeks and the field work was completed in twelve months, with a total of 44 visits and 37 interviews (Appendix 3). I completed a three stage thematic analysis of the data: uncovering evidence in the data itself, using the literature I had read, and reflexively considering my own experience. I analysed the data from several angles: if an action or incident supported or impeded thinking; the social workers' reactions to the observer and the similes and metaphors they used to describe their work which evidenced the emotional dimension of the work.

The interviews revealed the attitudes of the social workers to their work, and to the problems they faced. I discovered their preoccupation with vulnerable service users at risk of abuse and those with borderline personality traits, the conflict which they felt when required to implement discriminatory processes in their work or to intervene through pressure of public opinion rather than as a clinical decision. They expressed their feelings of professionalism, the impact of different policies and procedures on their time, how supported they felt in their work, and how much they learnt from each other in the group.

My increased presence in the District Team (p95) provided additional containment for the manager, while the interviews allowed all the staff to be 'held in mind' i.e. my mind. By my return two months later to discuss the findings, the team had set up a regular case discussion group and relocated the intrusive duty service. In this instance, the research process itself showed that the provision of mental space encourages creative problem solving.

The meta-analysis successfully provided evidence for comparison between the three teams of the five enabling factors, on which the generalisations and recommendations for practice below are based. The descriptions of the teams have been made fully anonymous and the final draft of this document was shared with key team members. In the time taken to complete the research, changes in staffing and resources radically altered all the teams, so that this record is made up of a number of 'snapshots' of dynamic organisations.

The Findings

The emotional meaning of the District Team's work

The District Team carried out assessments for the provision of care services for 'younger' adults with chronic debilitating illnesses. They had inherited 250 pieces of unallocated work when the adult services were restructured three years earlier. It had proved hard to clear this completely. Managers used vivid watery similes to describe their tasks eg 'to keep the work flowing' and 'to unstick any blockages'. They took seriously the danger of 'drowning' under a continuous stream of new referrals. They invested considerable resources in the duty system as a bulwark against the feared flood, with an administrator and duty senior wholly committed each day. This practical emphasis on movement and throughput was perhaps in unconscious contrast to the situations of their service users, which were more likely to be drifting, stuck, or declining. It delivered speedily completed care management assessments. But managers had no space to encourage social workers to develop innovative ways of meeting service user needs in the community.

The team also had to confront and manage the negative aspects of human nature and look under the surface of a presenting problem. In the depths was abuse of vulnerable, dependent people and mental distress. Indeed the team had to deal with 'the shit' in society both literally and figuratively. The undertow of child trafficking (see p160 - Visit 9D) and murder (see p153 - Visit 12D) was evident, as was the constant need to be alert to adult protection issues. Family members were often implicated and care workers too were not above suspicion.

The activity in the office seemed to form a thick screen that protected the local community from these negative facts. It did this so successfully that there seemed little awareness or understanding of their achievements outside the social services department.

The emotional meaning of the Hospital Team's work

The ability of the social work team to arrange speedy discharges was essential to the hospital's task. It was reinforced by legislation with fines for each day that a patient remained in hospital due to the lack of availability of social care. Social workers had to assess the patient on the ward, find accommodation, write a report and submit this to the panel for approval within three days.

The dominant emotional meaning of the work linked to the desolation and despair stimulated by the approaching deaths or mental and physical disintegration of the service users. The social workers, like the nursing staff, had to build up strong protective defences against these fears. Their task was to hold together the physical and emotional aspects of patients while they were discharged from hospital. This had necessarily been reduced to the mechanics of assessment for a care package or submission of papers to the continuing care panel. The team had a key role in the hospital system, and had accepted the values and priorities of the hospital. These priorities appeared to conflict with their responsibility to offer service users support in understanding their predicament. By the end of my placement in the hospital I thought the team was handling the workload in the only possible way - 'doing' not 'thinking'.

Meanwhile, the managers had absorbed the stresses and conflicts across the boundary of the hospital and community and were worn out, like parts of an overstretched machine. One had become ill; the other resigned and was about to leave the profession; a third had never been replaced; and the skills of the fourth manager did not match the newly graded post. Without a manager the team had no spokesperson to tackle the hospital about the malfunctioning administration. Unchallenged, the MDT meetings would continue to take the time of social workers without improving inter-professional understanding or communication. Finally there would be no challenge to the hospital agenda of making rapid discharges at the expense of the patient's emotional wellbeing.

The emotional meaning of the Mental Health Team's work

The primary task of the team was to support the mental and social wellbeing of homeless people, who had excluded themselves from society but continued to create considerable anxiety there. The parallel task was to protect society from the potential danger which these service users might pose. The service users often had reduced intellectual and emotional capacity due to years of street life, drug or alcohol abuse, borderline psychosis, personality disorders, or a combination of all these factors. They could also be volatile and occasionally violent.

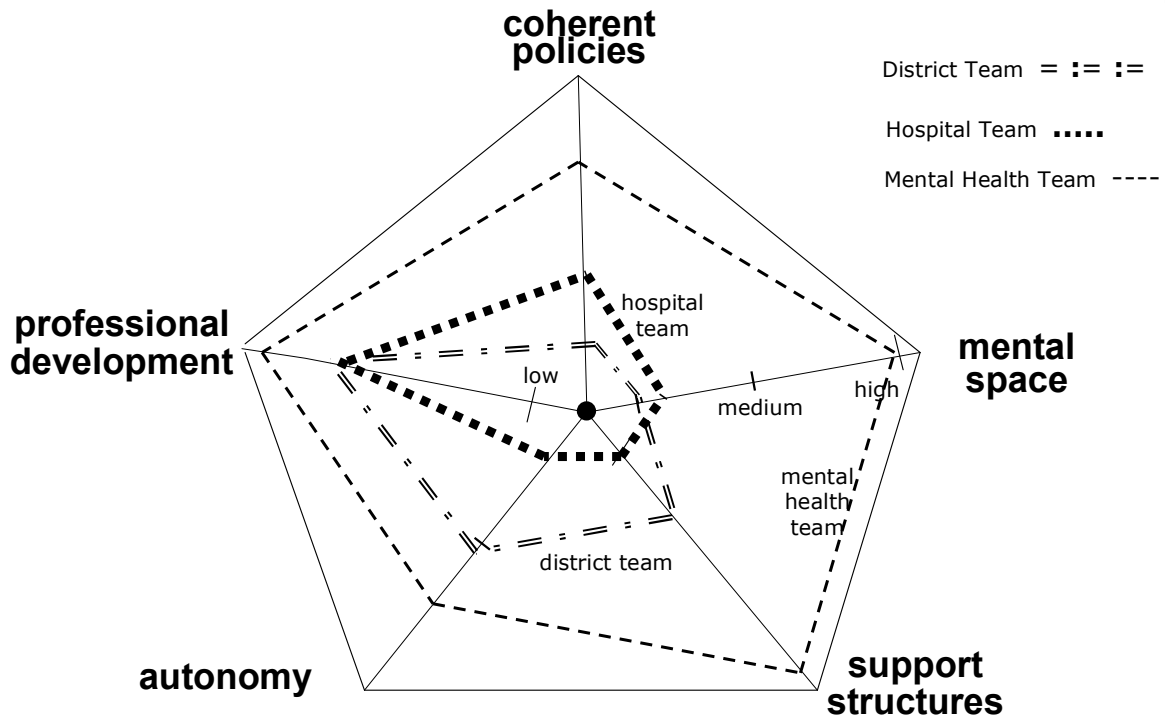
The office banter and friendships seemed to compensate for the bleak lives of their clients. This formed an important defence against the harsh streets outside. However, the team's need for group cohesion also appeared an important defence against some primitive anxieties prompted by the work. The team members seemed to hold a primitive fear of critical gaze from the observer, a fear which probably belonged to their service users. They also demonstrated a fear of exclusion and becoming outcast from the group. In order to avoid this, they were often quite conciliatory towards each other and other agencies. Given the diverse and difficult issues that faced the team every day, the need to provide as much cohesion and support to each other as possible is understandable. But the confident exploration of racial and professional differences could have ultimately added to the team's strength (Borrill et al 2000) and provided a role model for other multi-disciplinary and inter-professional groups.

The five enabling factors

The analysis described in Chapter 7 identified five enabling factors that were key to the prediction of team performance. I looked at each factor from a number of angles and drew comparative tables between the teams. I describe the factors and their subdivisions below, with examples from each of the teams.

Fig 8.1 the five enabling factors

Five Enabling Factors



Coherent policies

I noted the frequency with which policies preoccupied each team. I considered these from three angles - was their implementation confusing and problematic? Did the policies occupy a major part of their time? Did they have a major impact on how the team went about their social work task? (See Fig 7.4 p157).

The implementation of new policies initially put a strain on the teams and senior management. Judging from the experience of Direct Payments in the District Team, it takes around two years for a new policy to 'bed down'. By then adequate resources have emerged, appropriate structures have been put in place - and staff, referrers and service users are familiar with the procedures. For example, after an initial period of confusion and service user fraud a specialist Direct Payments Officer was appointed. He implemented a robust assessment system and enrolled a specialist charity to help the service users to manage their finances. This ensured that government targets for take-up were met.

'No recourse' work was a new policy area that was demanding and difficult for the teams. I was surprised by the number of cases the District Team held, and the hours that the team spent working out what to do. At the time there was little public awareness of this needy group. I learnt that the council was permitted under certain circumstances to provide destitute people with temporary accommodation until fit enough to be deported. This interface between immigration, community care and human rights law had proved a fertile area for specialist solicitors to obtain resources for their clients by threatening the council with judicial review.

'Continuing Care' assessments were a constant irritant. The senior managers of both the District and Hospital teams had to understand and implement the shifting sands of legal interpretations. I was in the hospital at the time of the delivery of the Grogan judgement (Chapter 5) on Continuing Care payments. In a densely worded judgement (see p162) councils were urged to reconsider their funding assessments. Unsurprisingly, the minds of the senior managers that week were filled with uncertainties on the 'right' funding decisions for the Continuing Care panel at the cost of other concerns, such as the management reorganisation currently being implemented.

The work of social workers and managers in the hospital was entirely dominated by the Community Care (Delayed Discharges) Act 2003 (Great Britain 2003). Under this legislation they were fined for each day a patient remained in hospital due to the lack of availability of social care. The operations manager had developed an expert grasp of its workings. But its apparent success disguised the extent to which the social workers had relinquished major aspects of their role, such as help for clients to come to terms with their predicament, in order to accommodate the hospital's requirements.

Cases where vulnerable adults needed protection caused concern to the District and Hospital Teams, and would preoccupy the social worker and line manager for a substantial period. Complaints from service users, some of which sounded 'vexatious', also added to the District Team's burden.

The Mental Health Team were familiar with working under the Mental Health legislation of 1983, but had begun to come across 'no recourse' cases amongst their homeless

service users. The criteria for providing services was whether or not the service user was suffering from a psychotic illness or possibly post traumatic stress disorder (PTSD). Social workers found these civil war survivors had a need for social care, if not for medical intervention, and wanted to help them but the legislation often prevented this. They complained that its repressive nature conflicted with their professional values.

In summary, issues around policy implementation often colonised the mental space of managers and social workers, leaving little over for thinking about the service users. There were examples of whole departments struggling to make sense of new government policies while other policies that had been efficiently implemented had unforeseen consequences – such as objectifying vulnerable older people and increasing the risk of abuse.

Professional development

A key finding in the research was that the majority of social workers in each team were highly motivated, with considerable skills in working with people from marginalised groups. Their feisty determination and enthusiasm reduced the impact on the researcher of the smaller number who felt undermined, burnt out, or had become detached from the group endeavour. I looked at each staff group from several angles – the proportion of engaged staff; who had chosen to work with this team; who were committed to further post qualifying training; who had other development opportunities; who could work in pairs and who held social work values (see Fig 7.5 p164).

Social workers had often come into post determined to complete the post qualifying award. However, they found Children and Families workers had priority for funding. Those who had achieved the award had extended their knowledge, as well as increasing their confidence and ability to perform in an inter-professional environment. All the social workers in the Mental Health Team had become Approved Social Workers for the first time and four other mental health colleagues were completing further professional training.

The difference in professional development showed up in two areas. First, social workers in the District and Hospital teams had few development opportunities in the day to day work. For example the manager was not invited to present his Team's work

to representatives of the Department of Health (p89). In contrast, the staff in the Mental Health Team were given different responsibilities - e.g. to liaise with a hostel and day centre, to be an advocate for the team and its service users, or to provide training for other mental health professionals and volunteers. Secondly, much work in the mental health team was carried out in pairs unlike the District and Hospital Teams. This had been introduced to make outreach visits in the early morning or late evening safe. It had positive benefits as the community psychiatric nurses and social workers gained support, expertise and confidence from this joint working. They also expected their work to be transparent and scrutinised by colleagues. Other social workers would benefit from this practice, particularly for the hospital's Multi Disciplinary Team meetings on the wards.

Mental Space

During my observations I identified 15 potential areas where most social workers could experience some mental space. I list them and compare them in Fig 7.6 (see p168): personal reflection; spontaneous talks with colleagues about work; social interaction; spontaneous discussions with managers; supervision; allocation meetings; case discussions; learning slots; team meetings; MDT meetings; internal management meetings; departmental meetings; team away days; consultancy; departmental training days.

Social workers in the District Team had few formal opportunities to discuss their work. They valued the chance to sit near an experienced colleague, or to talk to a team leader or senior who were always approachable. These were their main occasions for developing practice. Even the frequently mentioned monthly 'teatime talk' was mostly taken up by presentations rather than discussion. Owing to staff shortages, supervision was patchy during my visits. Managers would meet with staff for specific reasons eg adult protection or complaints procedures but regular supportive sessions did not take place. Departmental meetings on specialist areas were supportive for those who attended but longer standing staff wanted another 'Away Day' to discuss different internal structures for managing the work. The space in the team meeting was largely filled by the manager. He appeared to use continuous speech to avoid providing the team with any space to think.

Smaller offices helped the hospital social workers to form close relationships with their colleagues. They had to rely on each other in the maelstrom of Delayed Discharge legislation and the collapse of the management structure. The remaining managers formally replaced supervision with an 'open door' policy to cover the staffing crisis. Without supervision or functioning multi-disciplinary team meetings on the wards, they were dependent on the team meeting. This was the only wider forum in which they could explore together how to develop multi-disciplinary relationships within the hospital and across the social services department. It could not, however, replace the lack of a manager in dealing with the hospital hierarchy.

Bostock et al (2004) also found that two out of the three Children and Family teams which participated in their research lacked functioning supervision. Interestingly the team which did provide regular supervision - the Mental Health Team – did not want me to observe a session. It seemed that the expectations of this process had become so high that people feared scrutiny and criticism. One reason for this may be that supervision had been emptied of any emotional meaning, in the same way as much of the care management work. It had become an over-formal minuted meeting that focused on the facts and statistics needed for performance indicators and case records which would protect the organisation if anything went wrong. It was not clinical supervision offering a reflective space. Perhaps the result was that social workers and managers felt more comfortable seeking and providing support in a more informal environment. There did not appear to be any regular training or developmental opportunities available for those who had to provide staff support and clinical supervision.

Autonomy

Central government curtailed local authority autonomy in the mid 1980s. Funds were then allocated to councils only when their service plans met government criteria. Balloch et al (1995) found that high morale for front line workers depended on their ability to make decisions, and some authorities tried to encourage this. It enhanced professional effectiveness.

However in the following decade, governments became more prescriptive in many public sector professional areas. Lead social work professionals failed to influence the development of performance indicators at the introduction of care management in the

early 1990s. Consequently these appeared to be skewed towards financial rather than professional quality objectives. This resulted in the selection of indicators that were dissonant to the social work task and discouraged local innovation.

Of the three teams, the Hospital Team had the least autonomy and discretion over their work. The team had to take on every person who genuinely needed discharge (the social workers challenged those whom they thought too ill to consider moving). The timescales demanded by the legislation to assess home circumstances, interview relatives and produce a report for panel within two days, could 'bunch' to produce considerable pressure. Educating new health service colleagues into the procedures was a never-ending process.

The District Team worried that it would drown in the work. Unable to replace key staff team leaders had to cut back the incoming work if waiting times were not to increase. They were not then available for other management tasks, like supervision, evaluating the current system or inviting solutions from the team. However, the social workers, knowing they had the confidence of their managers, were able to negotiate imaginatively with their service users. For example, Marlene's tale (see p39) shows how she helped a brain damaged man to recover his life, who could easily have been left to be imprisoned.

The Mental Health Team, being a specialist resource, appeared to work throughout with professional confidence and autonomy. Admittedly there was less anxiety around elderly rough sleepers suffering from hypothermia during the summer when I was there. The team appeared to have a functioning performance management system and understanding of the different professional roles of the team members. For example the manager and occupational therapist shared the work plan which they had agreed at her annual review with the team. It was also democratic. One social worker commented that she would not work in a team where she was instructed on what to do by a consultant psychiatrist.

Support structures

The research revealed crucial aspects of daily activity that varied between the teams and affected the ability that social workers had to think about their work. Figure 7.7 (p174) makes a comparison between the teams under a number of headings:

management practice, administration, information, IT, finance, use of staff, statistics, resources, and the office environment.

Management practices in each team directly affected the availability of mental space for the social workers. The main variable was the team's ability to hold well chaired, well attended, and focussed meetings where everyone participated in discussion and where decisions were reached and implemented. The Mental Health Team achieved this with their weekly team-cum-allocation meeting and their weekly case discussion meeting. The hospital team had their fortnightly team meeting, which was well managed and fairly participative. The District Team's fortnightly team meeting lacked time boundaries, participative discussions and an effective decision-making structure.

Inquiries into tragedies often identify the paucity of administrative support. But they tend not to appreciate the extent to which these tasks preoccupy the social workers at the expense of thinking about their service users. This study found that the Hospital Team had the least effective administrative and IT support. Team members spent hours copy-typing assessment forms, queuing to send faxes, and entering invoices on the IT system for all the services set up. With the collapse of its management team, there was no capacity to challenge the hospital on the working standards of its administrators. By way of contrast, the District Team had some IT and business support, though the frequently changing records system was an unnecessary distraction. The proliferation of agencies contracted to provide home care had also increased their work load.

The District Team, however, had the most disruptive accommodation with no quiet space to work or think. The overall noise produced considerable stress, with social workers often unable to hold sensitive telephone conversations with chronically ill or dying service users. There was agreement that the duty system created and perpetuated the disruptive environment.

The Mental Health Team's multi-disciplinary staff group were deployed flexibly, which added skills to the team at no additional cost. Former staff, who were retraining in different professional areas, were also employed a couple of days a week to fill the duty officer role. This was the only staff group who did not complain about the IT

system or the demands of record keeping. Their senior administrator had developed imaginative information systems to which they all contributed.

In summary, Figure 8.1 (see p183) compares the performance of the three teams against the five enabling factors identified by the research. All the teams had professionally motivated staff with positive attitudes and a determination to meet service user need. The Mental Health Team maximised mental space to work creatively and consistently with a difficult client group, having clear boundaries for accepting work and managing their own staffing budget. The team out performed the District Team and Hospital Team in professional development, autonomy, coherent policies and support structures. Both the District Team and Hospital Team had limited opportunities to find and use mental space. This affected their ability to review critically the work which they were required to do. All five enabling factors are needed for social workers to respond to both the emotional and the intellectual demands of the work.

Implications for practice

Focus on vulnerable adults at risk of abuse and those with borderline traits

Social work leaders in government, universities and management should explain to legislators that some social work with adults does not fit into the 'empowerment / personalisation' framework. A substantial minority of social work is with people at risk of abuse or with borderline traits. Should the majority of the available professional effort be focussed on this group? It would be a more effective way of attempting to protect vulnerable adults and children. If agreed, the general public and media need to know this priority, social workers need to develop and maintain appropriate skills, and managers need to resource the support and time necessary to carryout the task. The timescales and targets currently established for the majority of social work with adults is probably insufficient for the work needed.

For example in the case of the Hospital Team, in order to effectively protect people with physical and mental frailties from abuse in care the social worker needs to develop a trusting relationship with the service user, rather than reacting to legal pressure and dealing with them in haste. Ego supportive work as used for children coming into care is important to avoid the reification of isolated older people. The social worker has to know the service user's personal narrative in order share understanding of their

predicament. This could be reinforced by a trial stay in residential care before admission, the involvement of any relatives or neighbours, the development of a free-style 'life story' book etc. Would you want less for your mother if she was alone in the world?

In the District Team some 'hard to reach' families continued their anxious love-hate relationships with each other and with those in positions of authority into the next generation. Social work teams could benefit from better understanding of their behaviour (analysed in Chapter 2) as part of their basic training. With robust support from senior managers, teams could experiment with ways of helping the service users while setting boundaries around their demands. Recent work from the 'Reach out – think families' projects may indicate the way forward.

Implications for social workers

When applying for a post, social workers need to establish what sort of regular mental spaces will be available for them – eg the nature and availability of regular supervision? case discussion groups? allocation meetings? consultancy? joint working with more experienced colleagues? in-house training? relying on their peers? They need to understand the team dynamics and choose to work in a culture that enhances their energy and creativity. As one social worker said 'You must have a vision of where you are going or you'll get pushed around both professionally and personally' (Int 11D).

Social workers need to seize development opportunities which arise - a presentation at a team meeting, setting up a meeting on a specific issue etc. The PQ Award system provides a valuable target to aim towards. If they can visit the most relevant community resources as part of their induction, social workers will gain a sense of the community which they have joined.

Implications for first line managers

Training in management practice and in providing clinical supervision

The social work profession does not provide basic management training for first line managers. Most managers employed by local authorities eventually complete some in-house HR and financial management training, sometimes continuing to a Certificate in Management Services, but voluntary providers are rarely able to access these. Just as social workers gain confidence through further training, so managers need the

confidence to challenge robustly their superiors on poor accommodation, inadequate IT, lack of financial support services, and the team's work priorities.

The first line manager is in a key position to encourage staff development, professionalism and autonomy. This research shows that an already stressful work environment deteriorates without well-attended and well-chaired team meetings. Case discussions, 'away days', and allocation systems - all with social worker participation - provide mental space and support development. Performance management systems, including a frank but supportive annual appraisal, provide the framework for the organisation. If managers are given personal development opportunities such as short 'job-swaps' across or between organisations (eg other local authorities or hospitals), they are also more likely to recognise similar opportunities for their staff.

Organisations want smooth-running systems with managers responsible for ensuring that the work is being dealt with in a timely way. However, the demands of audit do not provide managers or social workers with sufficient support to provide continuous engagement with troubled and troubling people. First line managers need training in clinical supervision to gain the skills to provide a dispassionate containing space and to receive this themselves. Then social workers will be able to reflect on those relationships that hover on the edge of their consciousness. Child and adult protection issues usually occur in uncomfortable and confusing environments. Professionals deserve clinical support to analyse the evidence - both cognitive and emotional - in order to understand the circumstances and to decide appropriate action.

A short period of training in management procedures is needed before taking up a post, followed by skills in clinical supervision for those who have not obtained a practice teaching award. Managers would then be more effective in nurturing thriving teams and challenging local and national politicians for resources, feeding back on policy implementation and contributing to qualitative performance indicators. These two aspects of management training could be readily dovetailed in to the Post Qualifying framework. It is vital that the GSCC responds to this need.

Implications for senior managers

Communicating with councillors, government officials, the general public and the media

As the media is now a key influencer of opinion - and the deputy prime minister has claimed surprisingly (Independent 3 March 2009) that the government has to respond to 'the court of public opinion' rather than to a court of law - senior social work managers and leaders must become more skilled communicators. They should imitate the London acute hospital which had a daily slot on national television for four weeks showing 'Hospital Heroes'. Why not social care next time? A major media slot would of course have to take account of service user vulnerability, perhaps by making the initiative user led.

This research found that each team protected the local community from the impact of numerous distressing or alarming situations, eg a brain damaged young man behaving violently in public (see p39) or a physically and mentally frail older person being bullied by her nephew (Int 2D). This protective screen and ignorance about their neighbours allows members of the community to split off their primitive fears and vilify both service users and social workers. As a profession we find it difficult to persuade funders and opinion formers that some valuable work remains unquantified - someone gaining independence in sheltered housing for the first time in thirty years (Int 9D), an adult son with alcoholism being welcomed for Christmas (see p92) - these smaller vignettes need sharing. Some of these prejudices might be dissipated if social work managers participated regularly at community forums and if local offices were encouraged to hold 'open days'.

Leadership

Senior managers can enhance their leadership skills through education and training opportunities. More learning is needed of best practice in other public sector organisations including the health, education and voluntary sectors both here and overseas (eg through short study visits). Central government should encourage social work departments to provide local interpretations and responses to policy demands. With different approaches to implementation, services could be compared and contrasted, and best practice adopted more widely.

There was a perception throughout the research that senior managers rarely 'walked the walk' and were seen as remote from the social work teams. This perception could

be reversed by regular visits to district offices, weekly bulletins to all staff, central forums where social work staff can discuss current issues with the departmental management team. The latter could find staff feedback on plans stimulating.

The voice of senior social work management needs to be heard at the top table of local authorities and health trusts in discussions on budget allocations. There is a perception that social work is readily marginalised by the more powerful professional bodies in education and health. Senior social work managers need to be seen by their staff to negotiate robustly for a fair share of the centrally allocated funds, to feed back on the effectiveness of new policies, and to contribute to new performance indicators that take note of the challenges of the work.

Senior managers need to ensure the provision of good office environments, IT resources, and support staff for social workers. Without these support structures, social workers are unable to fulfil their role which reduces their confidence in their senior managers. Delegation of resources to the teams enhances their commitment, autonomy, and creativity. It encourages local community involvement, partnerships with smaller voluntary groups and the potential for innovative ways of working. For example social workers would benefit by working in pairs to share expertise and understanding of difficult situations.

Implications for multi-disciplinary teams

The study found that the Mental Health Team thrived because the structured opportunities for mental space allowed democratic decision-making, shared responsibilities, creative approaches to service users, a safe working environment and an appreciation of each other's specialist skills. In contrast, the multi-disciplinary team meetings in the hospital did not allow for discussion or a sharing of perspectives. The culture was dictatorial rather than democratic, with no opportunities for reflection, discussion or creative problem solving. This supports the findings of Borrill et al (2000), that 'CMHTs who perceive their performance as highly reflexive are rated more innovative by external judges'

Implications for national bodies

This first decade of the 21st century has seen national social work bodies fragment and multiply. The development and maintenance of a shared vision has become harder.

The social work role itself has fragmented. Other professionals often undertake counselling, advocacy and 'best interest assessments' which were once part of the social work role. The Department of Health and the Department of Education Schools and Families and the Social Work Task Force could learn from 'Changing Lives', the Scottish Government's (2006) vision for social work which addresses a number of the key questions currently facing the profession. The Royal Commission's recommendation to cover all adult residential care costs (p162) was rejected but the Department of Health needs to compare findings on this and other divergent policies across the United Kingdom.

The General Social Care Council has improved the profession's performance through registration and the post qualifying framework. If first line management training were included within the PQ framework, the good practice of clinical supervision and mental space for social work teams could become widespread. The different national interest groups should establish an overall body for the profession – something missing in this country – which would act as a source of containment for social workers struggling to counteract the disintegrating forces in individuals, families, and society.

Final Comment

I was privileged to be able to look, listen and reflect on three different social work teams at work with vulnerable adults. The kindness, good humour and professionalism of the team members illuminated the research. Their candid responses allowed me to uncover the hidden and disturbing aspects of the work which they contain and manage for society. The research showed that social workers and managers need the energy and creativity found in shared mental space to work effectively with excluded and marginalised service users. Its availability depends on coherent policies, a commitment to professional development, a sense of autonomy and adequate management practice and support structures. I urge all readers to use their influence on behalf of front line workers and managers to take forward the recommendations above.

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Judy Foster
October 2008

Appendix 1 Research proposal

Research Proposal D60

Student No 9923468

September 2004.

How do social workers think on the front line?

What supports their thinking and what gets in the way of it?

Summary:

'A true comprehension requires not only an intellectual realisation but a simultaneous emotional response; neither alone will do'. (Bettleheim 1983)

Social workers work with people on the cusp of a psychosocial crisis. These are stressful situations both for the client and the worker. The latter are under considerable pressure to 'solve' the problem, knowing that the wider world is watching and waiting for one false move. Their ability to think is thus under constant attack, from clients - through projection, from authority figures in our blame culture and from the worker's own internalised issues. On the other hand a social worker's education and the support structures in their work aim to restore that ability to think.

This proposed project is to look across current fieldwork structures in mental health, child and adult care to try and find out more about what happens to social workers' thinking on the front line. By 'thinking' I include the unconscious dynamics in the situation as well as the cognitive and the emotional elements. Current emphasis in social work education and practice on decision – making, evidence-based practice, critical thinking and even reflective practice may be misplaced if it does not connect with the lived experience of the worker. From my background as a social worker, training manager and national development officer, I propose to undertake three case studies, spending time over a number of weeks observing staff in different learning and practice situations, interviewing them and listening to their accounts of their work and reflecting on my own counter transference experiences.

Aims:

- To find out how social workers are thinking on the job, using psycho-dynamic concepts to shed light on the process.
- To find out what they identify as their primary task
- To consider through observation, interviews and counter-transference responses in the researcher what supports their thinking and what gets in the way of it.
- To look at individual and organisational factors that may contribute to or work against social workers' ability to think.
- To explore thinking in three different areas of social work practice – children and families, older people and mental health to allow for generic findings and commonality in social work thinking.

Background to the research:

My interest in the impact that individuals and the emotional environment can have on our capacity to think was stimulated in part by seeing children flourish with sympathetic teachers and falter with others. I find my own thinking can be obliterated by strong emotions particularly of fear, anger or anxiety or confused by worry and preoccupations. When introducing the qualities of a 'learning organisation' into a Social Services Department I had the opportunity to notice the different environmental effects on staff performances. During my career I have been conscious of the impact that service users and their worlds, managers, colleagues and the current policy and working environment have on my capacity to think.

For different reasons discussed below society has moved from a co-operative venture to one of individualised risk and reward. Social work practice has followed this trend, reducing its attempt to help the excluded re-engage with their communities through a relationship with the worker. Now we assess the excluded for services, treatment or intervention whilst being inspected and regulated ourselves. The potential complexity of the relationship between the worker and service user is ignored. A Director of Social Services said (Care and Health 77, 3 August 04 p32) 'The role of professional assessors may become limited to complex cases in child protection and adult mental health'. This statement implies that assessment is the extent of the social worker role. However, service users and carers expect more. One said of her social worker 'I know she can't do anything, but I do need her to listen to me. It helps.'

Within a blame culture where a fall in star ratings can mean the end of a senior career, there is little interest in how the whole system works nor in the minutiae of everyday practice, rather a need to put the best possible gloss on every situation. The Director of Social Services in Haringey was not untypical in ensuring a good joint review rather than let inadequacies in children's services be exposed (Great Britain 2003 6.144). Inquiries into tragedies look in detail at the external actions of workers from an administrative and legal perspective. One hears the comment 'It must never happen again' with sinking heart. Human beings are fallible – that is our nature. Current policies are to construct impregnable systems, but in doing so, we need to take into account the people who have to operate them.

In this project I would like to focus on front line social workers and their managers, understand their view of their task and the theoretical frameworks that give their work coherence. I will examine the supports and pressures on their thinking from a systemic and psychodynamic perspective. The project may be relevant to two current projects from the Social Care Institute for Excellence. The first focuses on 'learning organisations' and ways of promoting them (Rosen et al 2003). The second looks at 'Managing risk within child welfare: promoting safety management and reflective decision-making' (Bostok 2004). This considers systemic and practice issues - and also learning from 'close calls'. It plans to report in November 2004.

Literature Review:

Thinking:

In this section I look at thinking from a number of perspectives: the broader frame, cognitive approaches, psychoanalytic ideas on the development of thinking and consider what is meant by critical thinking and reflective practice.

The potential breadth of the subject 'thinking' is large and unwieldy. Blackburn (1999) explores the arguments of philosophers on issues such as the mind and free will, and relates them to living today, while Burton and Radford (1978) look at the subject through a dozen essays on thought processes. Aristotle divided knowledge and thinking about knowledge, into three main areas. First he had the pursuit of truth through contemplation and argument, how most of us consider the study of philosophical concepts such as 'truth' or 'freedom' as in Blackburn's study. Second was the study of productive sciences to make something – be it mathematical models or a new house –where one might place the more cognitive psychological works like Burton and Radford's. The third area was the study of the sciences that dealt with ethical and political life to develop practical wisdom and knowledge.

I am taking this third arena, often referred to as 'phronesis' to analyse what happens on the front line of service provision. Leach (2002) in applying the concept of practical wisdom to post-graduate medical training says that 'medicine is not a productive art; it is a cooperative art. It cooperates with the body's natural tendency to heal.' Again he says 'To be fully available to their patients, doctors must be both present and attentive....it is the basis of making and learning how to make good judgements; it is the basis of practical wisdom', which puts one in mind of Bion's theory of thinking.

Bion (1967) explores the idea that thinking has to develop to cope with thoughts, not the other way around. He describes how an infant's pre-conception (of a breast for instance) when it meets the realisation/ actuality of the breast gives rise to a conception – the thing itself – the thought. He goes on to argue that thoughts develop when the infant is frustrated in the instant realisation of its conception. A growing ability to tolerate frustration and to use thoughts in its place sets up a thinking process. When the infant cannot tolerate frustration it evacuates the intolerable feelings through projective identification into the mother. Bion held that a functioning mother would feel the unmanageable feelings (that the infant was going to die for instance) but survive and manage them. In her handling of the child she detoxifies the feelings and hands them back in an acceptable form. She provides the container for the infant's primitive feelings, which gradually the infant internalises and develops an increasing capacity to handle.

Winnicott (1958) saw this ability to tolerate frustration as a key element of the infant's ability to use mental space and develop the capacity to be alone. He describes the infant being alone in the presence of the mother, when the mother lends her ego maturity to support the infant's ego immaturity. Gradually her actual presence can be represented by the cot or the immediate general environment as the infant internalises this good object. Britton (1989) describes how the child's recognition of the parental relationship provides a triangle of protected space. This space outside the infant can be observed and thought about. 'A third position then comes into existence from which object relations can be observed. Given this we can also envisage *being* observed. This provides us with a capacity for seeing

ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves while being ourselves.’ (p87). Garland (1991) in her exploration of trauma points out that one of the noticeable consequences is that ‘the event appears to alter the survivor’s capacity for symbolic thinking, it alters the capacity to ‘imagine’ something quite vividly, while simultaneously knowing the event is not taking place in external reality’. She goes on to remark that ‘the capacity for symbolisation, and for thinking ‘about’ something is a necessary part of working through a psychically painful experience’ (p509).

These thoughts on the capacity to think about and reflect on a situation are expanded by Schon (1983) in his exploration of the reflective practitioner. He suggests two main divisions – ‘knowing-in-practice’ being the intuitive judgement and skill used and ‘reflection-in-action’ for the questioning, ‘what do I make of this?’. This division is similar to the intuitive action and mental simulation noted by Klein (2000). In social work, supervision sessions can provide the opportunity for a worker to reflect in the company of the supervisor on what is going on in a case, with the supervisor allowing the worker to verbalise their anxiety which the supervisor then tolerates or ‘contains’. (Barker 1982) This then frees up the mental space to allow the worker to take a third position and think.

Rushton (1996) points out that the powerful feelings aroused in child protection work can affect a worker’s capacity to make rational decisions. In his study of supervisors, they said they had a role to play in responding to these feelings but that the need to inspect and advance the work was as important. There were signs that the supervisors were not confident that hearing the anxiety would in itself free the worker up to think more clearly. He quotes one saying ‘If they tell you what they’re feeling, what the hell can I do about it?’ (p364) To hold on to the value of providing reflective space and a third position for the worker in an environment dismissive of ‘feelings’ and concerned with delivery and performance demands more confidence and experience than is often available.

There are a number of models of critical thinking and decision-making discussed in a social work context. Reder and Duncan (1997) building on their earlier work (1993) analyse all ‘Part 8’ Reviews in one year and develop a model of assessment that they refer to as a ‘dialectic mindset’. The practitioner uses initial information to form a hypothesis of their own about the problem, adding more information through other sources and interviews. After considering alternative explanations they arrive at a synthesis on which they decide on action and interventions. This is very similar to the ‘mental simulations’ described by Klein (2000 below).

Munro (2002) examines both real-life decision-making and decision theory and their applicability to child protection. She concludes that the former are rapid and provide ‘good enough’ solutions, while decision theory with its multiple tree structure is worth using when the cost of error is great and when reasoning needs to be open and accountable. However I think both Munro and Reder and Duncan underestimate the impact on thinking and decision-making of the unconscious processes between users of services, individual workers, the teams and the organisation.

In a system that ‘pushes practitioners away from a personal relationship with users towards a more formalised relationship based on procedures and rights’ (Cooper et al 2003 p60), social work seems embarrassed to confess to ‘the cluttered realities of

our day-to-day practice' (Applegate and Bonovitz 1995 p7), let alone the 'internal conflict about the very nature of social work activity' (Preston-Shoot and Agass 1990 p164). Perhaps we feel guilty that we cannot fix other people's damaged relationships as efficiently and effectively as medical staff fix a damaged limb in a television drama.

Klein (2000) found that errors in decision-making can rarely be neatly identified to faulty reasoning, rather the errant workers are 'victims of poor design, poor training and poor procedures' (p268). He concluded from his studies that workers approach problem solving in two ways: intuitively, where experience has been internalised and by making mental simulations – comparing current facts with past experience and testing out the 'story' or hypothesis. Practical wisdom is also referred to in the TADMUS project ('Tactical decision-making under stress', Cannon-Bowers and Salas 1998) where a team of psychologists were asked to analyse decision-making around military actions. They looked at 'naturalist decision making' (p23) or 'how performance occurs in the real world'. In contrast, Sheldon and Macdonald (1999) argue robustly for evidence-based practice, using the evidence of randomised controlled trials. They advocate the work of Gibbs and Gambrill (1996) which looks at critical thinking for social workers. However a study of the text shows that while promoting a culture of thoughtfulness at work, they focus on the cognitive evaluation of arguments but neglect individual or group dynamics, give a disappointingly one-dimensional view of thinking on the job.

The policy environment:

The position of social work now reflects major changes in society that took place at the end of the 1970s and during the 1980s. The post-war political consensus could be said to have ended in the moral emptiness of the 'Winter of Discontent' in 1978. The following decade of 'Thatcherism' radically changed society. With lower taxes and less state provision, individuals can choose how to spend their money. But individual success also highlights individual failure. We increasingly blame others when things go wrong in their lives, while social factors such as poverty and disability are ignored. Increased disparity in earnings and the speed of modern technology also impact on the individualisation of society. There has also been a shift from a paternalistic view that the state should take risks on behalf of society. For instance, the decision to build a chemical factory would need to weigh the risks to a community of unemployment against those for its health and safety. Now the electorate demands to know these arguments and how the risks have been assessed. In his seminal book 'Risk Society' Ulrich Beck (1992) describes the move from a social consensus to work together for mutual benefit to an individualised society where risk and blame are shared out. Parton (1996) broadly supporting Beck's thesis, moves the argument on to the position of social work. His central argument is

'that risk is not a thing or a set of realities waiting to be unearthed but a way of thinking. As a consequence, social work's increasing obsession with risk points to important changes in both the way social workers think about and constitute their practices and the way social work is itself thought about and thereby constituted more widely.' (p98)

He goes on to argue convincingly that the concept of risk gives the expert who understands the risk more power and makes the individual appear vulnerable. This, along with increased litigation has contributed to the current blame culture.

Certainly social work has been transformed in the last twenty years both in its education and its practice. For instance, child abuse inquiries, those painful expositions of human frailty, focus on a legal concept of blame and place responsibility more on officials rather than the perpetrators. In response to this, during the 1980s and 1990s social workers were entirely tasked with assessing and prioritising children at risk, contracting out any positive or therapeutic interventions to other bodies. Sure Start and Connexions services for example have taken on traditional social work tasks. The transfer of children's services from the Department of Health to the Department for Education and Skills (Department for Education and Skills 2003) could remove stigma by making children and families services universal or could reduce investment for children in need, as greater priority is likely to be given to the schools budget. The new department is keen to encourage the development of integrated services for children and families and multi-agency Children's Trusts are one model of service delivery being piloted.

In adult services, the NHS and Community Care Act (1991) attempted to halt the dramatic rise of residential care and overcome the uneven provision of support services by introducing the retail concept of older or disabled clients as consumers who could 'pick'n mix' necessary services, with the social worker acting as co-ordinator. While this is in theory an empowering approach, there is a danger that workers cease to recognise the powerful emotions that different losses, chronic illness or disability may provoke. The case in March 2004 of a husband killing his wife of 67 years when faced with her 7th move in care in two months (Care and Health 75) when 'all involved acted with the best of intentions' (p14) is a tragic illustration of the difficulty people have in acknowledging the emotional aspect of older peoples' lives.

On the positive side, the National Service Framework for Older People (2002) has already reduced the amount of ageism in the NHS by increasing necessary health interventions for older people. Much is now expected from the Single Assessment Process, where good information systems can reduce the amount of duplicate assessment between health and social care services. The current Minister of Health for Adult Services, Stephen Ladyman, has restructured the policy division in the Department of Health to bring together a number of different initiatives under Adult Care services and is currently holding an email consultation on a vision for adult services prior to publishing a discussion paper in the Autumn (vision@scie.org.uk)

Mental Health has with cardiology and cancer been one of the three health priorities since the NHS Plan (2000). It has led the way on partnership working between Health and Social Care through the implementation of joint trusts and the secondment of social service employees to the Health Service. With the inspection of community mental health services now transferred from the Social Service Inspectorate to the Healthcare Commission, there are continuing concerns that social perspectives will be increasingly ignored in the delivery of services (www.spn.org.uk).

Additional planning blight has been caused by the delays in producing a new Mental Health Bill (2002) currently dominated by the Home Office and forensic concerns. A new draft is promised for September 2004. Meanwhile the Mental Health Act Commission and the Approved Social Worker role continue for a fifth year of uncertainty. Inquiries into fatalities (eg Richie Report 1994) have encouraged public suspicion that care in the community, facilitated by pharmacological advances since the 1960s, fails many people with mental ill-health and puts other citizens at risk.

Audit:

Rustin (2003) argues that in a society no longer willing to trust professionals and with shrinking government responsibility audit and inspection are used to establish greater public accountability for all the new non-governmental bodies. The system is then used to enhance and enforce competition. He points out the irony for a system that emphasises the importance of 'evidence-based practice' yet has little regard for any evidence of its own effectiveness. Cooper (2001) suggests that 'a whole culture of control sprang into being' to deal with the guilt, failure and blame now circulating in society after the collapse of trust in professional self-regulation. He called this 'the culture of anxious regulation,' referring both to the anxiety it is defending against in society and the superego aspects of critical inspection. Wheeler (1999) laments that 'We value only what is measurable rather than moving to a situation where we measure what we value.'(p146). I would contend that this competitive system leads employers to want staff to do only what is measurable in their performance criteria, such as assessments, rather than something less tangible such as sustaining a challenging relationship.

Audit systems can reduce creative thought and innovative action but more dangerously, they can subdivide complex tasks so no-one takes responsibility for the whole system (Hirschhorn 1997) as was discovered in the Climbié Inquiry (DH 2003). There is evidence too that these audit processes themselves can be fallible. For instance in the months prior to Victoria Climbié being referred to Haringey Social Services, a Joint Review (1999) by the Audit Commission and the Social Services Inspectorate recorded that 'The social workers generally manage risk and urgency well' and "This is mainly due to good leadership supported by an enthusiastic and committed staff group'. This illustrates the need for audit to be well done if it is to be done at all.

Education and training:

The world of social work education, training and staff development has been subject to much debate on appropriate knowledge and practice. Howe (1996) suggests that social work is 'defined by the evolving relationship between the state and the individual' (p79) and that its theories and practices reflect the times in which they live. Professional social work training after the Second World War was based on a sound social science framework to equip staff intellectually and emotionally to manage and make sense of the deprivation and distress they would be working with. However political involvement increased again when the conservative government blocked attempts by the Central Council for the Education and Training of Social Work (CCETSW) to introduce a three-year qualification in the 1980s. In the late 1990s the Department of Health dismantled CCETSW and took charge of the development and establishment of the new Degree in Social Work. It used National

Occupational Standards (Topss England 2002) to structure the knowledge and skills input.

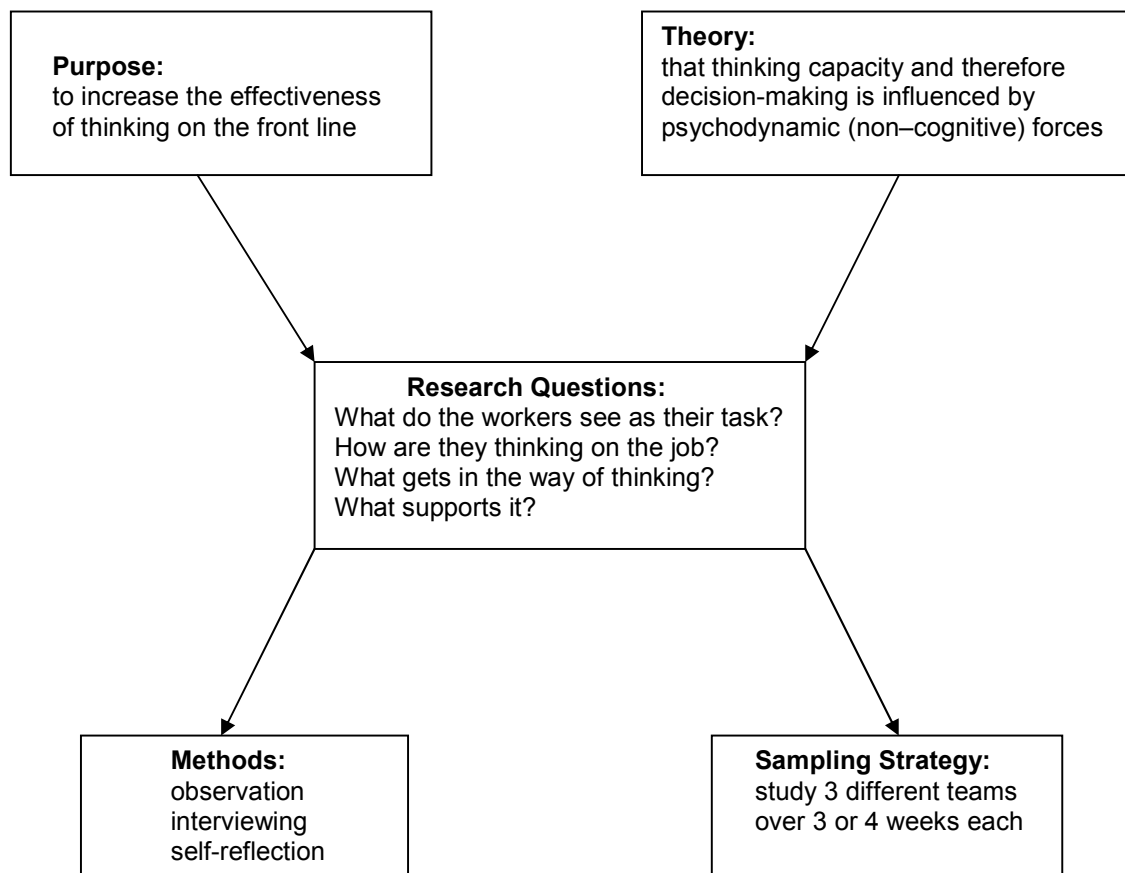
Since the foundation of Industrial Lead Bodies in 1986, now being reconstituted as Sector Skills Councils, there has been a tension between the universities and higher education on one hand and the vocational schools on the other. Social work sits uncomfortably between the two, with cries for 'street-wise grannies' (Bottomley 1992) conflicting with the demand for confident, high performing workers in a complex and stressful environment. The argument is far from over. Jacqui Smith, the health minister, introduced the new degree in May 2002, saying 'Social work is a very practical job; it is about protecting people and changing their lives, not about being able to give a fluent and theoretical explanation of why they got into difficulties in the first place' (Guardian 29 May 2002) The Sector Skills Councils are responsible for the development of 'occupational standards' for all areas of employment. These standards do not readily measure the intangible results of 'people work' and the social work standards are more rigidly defined than the earlier competencies used in the Diploma in Social Work. Given these changes in social work education over the last twenty years, it is quite likely that social workers in one team may hold different theoretical positions from each other and those in another team.

Social work has been criticised for the continuing failures to protect children from their murderous parents or, less frequently, from the trauma of unnecessary separations and court actions. Inquiry teams into child deaths assume they understand what happened (Maria Colwell 1974, Maria Mehmedagi 1981, Victoria Climbié 2003) and comment freely on administrative, legal, personal and organisational failings but pay little attention to the impact of the core task on individuals and the working environment. In each of the above cases a non-professional – the school assistant, the escort, and the child minder – saw something was wrong and attempted to bring it to the notice of the authorities. Reports rarely attempt to set out what was happening for the workers. Margaret Rustin's paper (2003) provides an exception when the reader has to face up to the pain that the workers attempted to avoid.

Participants and methodology:

Data collection:

What research methodology will deliver the required information?



(Robson 1993 p82)

Possible outcomes:

My hypothesis is that a worker's ability to think on the job (and therefore take appropriate action) will be linked to the mental space they have. However, the space will often be occupied by anxiety and other emotions. These emotions can be contained by symbolisation, which stops them invading the mental space and allows productive thought instead. The effectiveness of a worker's thinking may therefore depend on the opportunities they have to symbolise the emotional content.

Process:

Conscious of the splitting up of Social Services Departments, I would like to take the opportunity to look at three areas of social work thinking on 'duty': in a child care, adult and mental health team. After initial contact and conversation with an interested manager, I will attend a team meeting to describe the process of the observation, to be spread out over a period of a month, with a half-way meeting and generalised feedback of findings at the end (see annex 1) Confidentiality issues will be explored and reinforced.

Before deciding on the research methods I weighed up their appropriateness using Robson's (1993) description of methods for 'real world research'. For instance while my approach to the three teams needs to be consistent, it will not be 'quantitative' in the form of a fixed design study, nor use surveys, questionnaires, tests or scales. I do not think the material is concrete enough to be amenable to such investigative methods. I also expect some of the research questions to change or emerge during the research. However, a 'case study' approach, where I could use the same multiple methods in each team could be appropriate. I wondered if it would come under the category of 'action research'. But on reflection, although my presence will inevitably have an impact on the teams I will be looking at, I will not be engaging team members with me in delivering an agreed programme of change – although there may be changes they wish to make at the end of the project.

Throughout my negotiations I will be aware of Healy's points (1999) quoted by Cooper (2001) 'Being observed, especially if we are being observed in a crisis situation, may evoke the feeling of dread that what we are doing is wrong and will be exposed to the world to be critically judged by others.' And again on audit, 'Superego type audit activity is characterised by a dread or terror in those being audited of being found out, being criticised and being harshly judged...In contrast, a clinical audit process that is ego-driven stems from curiosity, a wish to learn about one's working practices and a desire to perform better' (1999 p54-5) I am undertaking this project in the latter, ego-driven state.

Observation:

6 observations in each site: 2 half-days in the duty team, 1 team meeting, 1 allocation meeting, and 2 supervision sessions

To inform me when observing this environment I will draw on the work of Menzies (1970), Mattinson and Sinclair (1979), Obholzer and Roberts (1994), Hinshelwood and Skogstad (2000), Armstrong (1991) and Hirschhorn (1997) who all offer a psychoanalytic perspective of organisations. Preston-Shoot (1996) has additional thoughts on the use of reflective space in work groups. The Social Care Institute for Excellence (Rosen et al 2003) has identified eight key learning settings in organisations: supervision, team meetings, PQ or AA mentoring, practice teaching, in-service training, individual continuous professional development, service user and carer participation, and other meetings such as briefings for councillors. These may all be areas where thinking is more visible.

I would like to start my observation by spending time in the 'duty room' where workers are carrying out a particular core task of the organisation. However I found at a brief pilot I carried out in a duty team, that attempting to become 'part of the furniture' as a benign observer-as-participant 'someone who takes no part in the activity, but whose status as researcher is known to the participants' (p319 quoting Gold, 1958) too alien in a one-off situation. So I have decided to ask for multiple visits to the workplace and will factor in a shift to 'participant as observer' role. I discussed this pilot observation with my supervisor, noting the need for ongoing supervision when observing teams and the need to develop recording skills both of the observed material and of my counter transference responses.

Interviews:

6 interviews in each site: 1 manager, 1 supervisor, 3 social workers 1 support worker

These will allow the participants to expand what was going on for them during periods of observation, allowing for some cross-comparisons between the researcher, the participant and the observation.

In a pilot interview with a former colleague at the end of his shift, I noted the need for adequate recording techniques both physically (the speed and volume of the interviewee's voice on a tape, the length of interview) and practically (the challenge of recording researcher reactions in addition to everything else)

Self-reflection:

Using the skills developed in infant observation and an observation of a working group, I hope to triangulate the study in each site by keeping a record of my feelings and counter transference responses to the experience.

Data analysis:

'There's nothing more practical than a good theory'
(Kurt Lewin Quoted Cannon-Bowers & Salas p17)

The material from the observations, interviews and researcher reflections will be analysed using psycho-dynamic theories of transference and counter-transference and the individual and organisational defences of denial, projection and splitting. I will be using a similar approach to Hollway and Jefferson (2000) in considering each person interviewed as a 'defended subject' ie attempting to defend themselves from the anxiety in their work and their lives. The pilot interview described below, demonstrated this dramatically.

The subject spoke with confidence at the start of the interview about the cases he had dealt with. His language and iteration of 'so that one went away' illustrated his view of the primary task. Then one case caused him to sound fragmented and confused. It was high profile and therefore for him, high risk, and the increased anxiety in his voice was evident. He interchanged events from two different days and it was hard to understand what was going on. The case in fact made him ill and he had to hand over the shift to a colleague for a number of hours. As the interview progressed, it clearly began to have a containing effect on him. As he talked about what could have happened to him if it had gone wrong and put his fears into words he moved into the third position and seemed to regain his capacity to think, spontaneously telling me of an appropriate action he could have taken to meet the needs of the client and relieve his anxiety.

As several of us in D60 are considering proposals that may add value to each other, the use of a computer programme such as NVivo to record and analyse the data may prove advantageous.

Implications of the study:

I hope that the study will throw some light on how far workers are able to think cognitively and emotionally as they go about their work. If we can increase our understanding of the different influences and factors that either enhance or inhibit a worker's ability to think, we may be able to contribute to helping both workers and organisations be more robust and effective. The study may also contribute to an appreciation that sustaining relationships with people in distress is a complex, difficult business that needs careful support rather than attack. At this time of major structural change, it may contribute to the recognition of the value of psychodynamic perspectives in the new organisations.

Dissemination of findings:

I will offer workshops on the findings to the 3 sites and apply to a number of specialist social work groups including the Tavistock for opportunities to share the findings. I intend to publish an article drawn from the material.

Duration and phases of the study:

- Submission of modified research proposal to D60 examiners board – August 04.
- Submission of Research Protocol to Research Committee and Research Ethics committee
- Finding research sites
 - Site 1
 - Site 2
 - Site 3
- Writing up results
- Submit to D60 Board

Appendix 2 Information for teams

Research Project –

‘How do social workers think when on the front line?’

How do they reach decisions?

This research project is being undertaken by Judy Foster as part of her doctorate in social work at the Tavistock Clinic. After a career in an inner city social services department – practitioner, team leader and then training and staff development manager - she became a development officer in CCETSW, going on to work in Topss England on the mental health training framework. Is currently co-chair of the Social Perspectives Network (www.spn.org.uk)

The social work role has changed considerably during her career but the one consistent aspect is that it is relationship-based. Social workers therefore have to think both cognitively and emotionally about a situation, as well as take account of the unconscious dynamics. This means that much of the guidance from lawyers, DH officials, and even lecturers and trainers can miss the point. Encouragement to use evidence-based practice, critical and reflective thinking or assessment frameworks may not be taking account of what happens in the field.

For instance, what knocks our ability to think straight? Strong emotions certainly, fear, anxiety, sadness. Then there are the preoccupations of living, the working environment, overload and more. But in the main, we recover our ability to think. How? She would like to look, listen and understand what happens during the working day in three different teams: mental health, child care and an adult team. She will try and understand what its like for social workers and what happens to their thinking as they do their job – when is it swamped and when does it survive?

She is not focussing on any individual’s work but on the dilemma that is part of the job itself. With the integration of services and weakening of local authority links, it’s important that the profession can say ‘This is what we do and how we do it’. A better understanding of the dynamics could also lead to better-placed resources to support workers to meet the demands of the proposed Post Qualifying Awards.

If any team is interested in being part of the project, she will:

- talk to the manager
- come to a team meeting to discuss it .
- explore the confidentiality issues and give all the team an explanatory letter (as required by the University of East London’s ethics committee)
- spend 2 or 3 half-days a week for 3 or 4 weeks to observe different situations where thinking is likely to be visible (the duty room, allocation meetings, clinical and management supervision etc) and subsequently interview staff.
- Arrange a time to fit in with the team
- hold an initial, midway and final discussion with everyone involved
- hold a workshop for the group of the findings and implications, which if they liked, could be repeated for other teams in the borough
- let this project contribute towards any other research initiatives in the Borough
- use the findings from the three different teams as a whole which may contribute to a future publication.

So do contact her at the email address below

Judy Foster

judy.foster@tiscali.co.uk

December 2004

Appendix 3 Visit and interview schedule for the three teams

District Team: April - July 2005.

Observation Visits: 19 April, 20 April, 5 May, 6 May, 9 May, 18 May,

Interviews and participant observation visits:

14 June Rich (1);
20 June HIV;
21 June Dominic (2), Jill (3);
22 June Liz (4), Leroy (5);
27 June, Mary (6), Peter (7), Sylvia (8);
29 June Valerie (9), Sarah (10), Marlene (11), Tony (12);
4 July Sonia (13), Yvonne (14);
11 July Vivienne (15), Fiona (16), Hazel (17) ;
12 July Anna (18), Andy (19);
22 July Laura (20).

Hospital Team: September 2005, January – February 2006.

Observation Visits: 2 September; 6 September; 18 January, 19 January,
9 February, 21 February.

Interviews and participant observation visits:

1 September Mary (5),
9 January,
12 January,
16 February Vincent (1),
17 February Linda (2),
27 February Dawn (6),
28 February Kelly (4),
1 March Terry (3).

Mental Health Team: April – May 2006.

Observation Visits: 3 April, 7 April, 13 April, 24 April, 26 April, 2 May

Interviews and participant observation visits:

14 March,
5 April,
5 May Julia (1);
8 May Lynne (2), Gill (3);
9 May Ed (4), Dave (5),
10 May Fraser (6), Nancy (7);
11 May Jane (8), Carol (9), Anna (10),
17 May Consultant psychiatrist (11).

Appendix 4 Interview questions

Extract of letter to COREC

Chair
Huntington Research Ethics Committee,
Cambridge, CB1 5XB

24 November 2005.

Full title of study: How do social workers think on the front line? What supports their thinking and what gets in the way of it?
REC ref no: 05/Q0104/128

Further information or clarification required

- i) Interview details: I will keep the interview relatively unstructured to allow participants to reflect and develop their own core narratives (as developed by Cartwright (2002) in his Psychoanalytic Research Interview). I will introduce myself, briefly outline the purpose of the research, explain that there is no fixed duration for the interview, but it usually lasts around one hour and then ask each participant:
 - 'please tell me about a situation recently that has been rather demanding and required a lot of thought?'
 - With prompts around a) the support they used? (managers, team members, others involved, partners, friends) b) any space they found to think through things?
 - Ending with 'and is there any work that you feel particularly please with?'
 - In conclusion I will ask them factual details of employment, professional qualifications and continuous professional development

27/05/2009